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## STATE MEDICAL JOURNAL

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ANNUAL MEETING—WEDNESDAY, THURSDAY, FRIDAY, APRIL 26, 27, 28, 1961

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## Medical Leadership in Rehabilitation

**T**HE REHABILITATION OF THE HANDICAPPED person to his maximum capacity for functional, social, and economic independence may require a coordinated process in which several professional groups participate. Some patients need only single services, such as physical or occupational therapy. Others require a comprehensive procedure beginning with a complete medical appraisal of the mental and physical status and including an analysis of the social background and the motivational factors and a vocational evaluation of employment potentials and capacity for retraining.

Whether simple or complex, rehabilitation begins with medical care, preferably concurrent with the latter rather than subsequent to it. Certainly, the physician is not the sole determinator of the full potentialities of the patient and he must rely upon the social workers, the therapists, and the vocational rehabilitation counselors for their professional contributions. The physician is responsible for determining the level of mental and physical improvement the patient is likely to reach, the intensity of medical and other services the patient is capable of accepting, and the time such services should begin. Likewise, it is his responsibility to the patient, throughout the entire rehabilitation procedure, to be certain that the latter's health status is maintained at an optimal level.

These medical functions are shared by all physicians, regardless of specialty, who care for patients with any disease or disorder which may leave a residual disability. Responsibility cannot be left for the very small number of physicians who have chosen physical medicine and rehabilitation as a specialty and have received board certification in this field as a mark of their exceptional professional competence. To this group must be assigned the responsibilities for the management of very difficult cases, for the organization of special rehabilitation services, and for providing consultation to other physicians as necessary.

Unfortunately, there are many physicians who have not taken an interest in or accepted responsibility in regard to the rehabilitation aspects of their patient's medical problem. As a result, complaints of the following types are often made by nonmedical agencies administering rehabilitation programs, such as

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I. J. Brightman, M.D., Assistant Commissioner Chronic Disease Services, State of New York Department of Health. Reprinted from New York State Journal of Medicine, April 15, 1960.

vocational rehabilitation, sheltered workshops, or welfare medical care (Aid-to-the-Disabled):

1. Physicians frequently fail, either deliberately or by just not getting around to doing it, to provide the necessary medical information to assist the agency in determining the eligibility of the patient for the rehabilitation program.

2. Physicians often write down, "totally disabled," without reporting any clinical findings to back up such a statement.

3. When adequate clinical reports are submitted, physicians too often state that no rehabilitation services are indicated, when it is known by both medical and nonmedical members of rehabilitation teams that patients with similar types of handicap often show good responses to rehabilitation.

4. It is recognized that rehabilitation services are not adequate in many areas of the State. Yet several of the existing high quality facilities are having administrative and financial difficulties because they are not receiving sufficient referrals from the physicians in the community. On the basis of numerous studies of the prevalence of disabilities in a community, it appears that there are many patients just not being referred for available services.

5. When patients are referred, the physician's request is often made for a single service, such as physical therapy or occupational therapy, when it is obvious to those experienced in rehabilitation that the person requires a comprehensive evaluation. Such persons often have problems in adjusting to their disabilities, which may be interpersonal or may relate to their dealings with their family or their community. On the other hand, it may be necessary for them to have a complete change in work habits or be trained for a new vocational field because the disability prevents them from returning to their former area of occupation. Thus, rather than a few physical therapy treatments a week, they should have a social evaluation and a prevocational counseling and testing service to be followed by actual vocational training if indicated. All of these services should be begun at the earliest possible time.

6. Physicians rarely consider the current labor market or the types of jobs available in the community when recommending handicapped patients for certain jobs. The most common complaint by employment specialists is that physicians state that the patient is suitable for "light work," without having any idea of what "light work" involves. The classic example is the referral of a patient for a position as night watchman, when it is well known that the watchman must make rounds through a multistoried building every hour and be ready to take quick action in case of fire or intruders.

Related to this lack of medical leadership is the frequent tendency of many nonmedical agencies to take for granted that they are the leaders in the rehabilitation field and that physicians play a very secondary role, simply a source for which medical services may be purchased. This seems to reach a peak in the current Federal legislative proposal for a Federal program for "Independent Living Rehabilitation" (primarily a medical rehabilitation program for handicapped persons with no potentialities for return to employment) which would be placed in the vocational rehabilitation unit of the states. This bill (HR-3465) is being sponsored by the National Rehabilitation Association. In a widely distributed "background statement," this association declares that only vocational rehabilitation counselors have the philosophy and the experience to undertake such a program. While holding that rehabilitation for independent living is not primarily medical, the statement emphasizes that the vocational counselors have had lots of experience in running medical programs, and are perfectly capable of doing so.



Thus we see here the pattern which is characteristic of phenomena in other areas of medical care. Whenever physicians fail to exert the necessary leadership in medical problems, there will be lay groups ready to step in and do it for them. It is still our philosophy that physicians should have the key role of responsibility for problems which are primarily medical.

Thus we must face the question of "who leads in rehabilitation." Medicine is not the only discipline concerned with the rehabilitation of disabled persons, whether the objective be employment or a maximum degree of independent living. However, the physician is a very important member of that team, and if he is not the captain, he would at least appear to be the quarterback. It is up to him to determine the medical potentialities of a patient and what the patient's mental and physical status will accept.

If the physician fails to carry out this role, there is the immediate danger of unfairness to the patient who may thus not achieve his full potentialities. There is also the long-range danger of handing over medical problems to nonmedical groups on a silver platter.—I.J.B.

#### ETHICS CORNER

**T**HE SIZE of a physician's sign is regulated by the Medical Practice Act, and violators may be brought before the Board of Medical Examiners for an explanation of such violation.

The Act requires that:

*"Section 145 (c) Each physician or surgeon may exhibit on the door or wall of the building wherein he practices not more than two signs on which may be placed the name and title or degree of such person and his specialty, the letters of which shall not exceed three inches square. In addition he may exhibit such sign on the door of his office in addition to those on the door or wall of such building."*

APRIL 26, 27, 28, 1961

Program

ANNUAL MEETING

MEDICAL and CHIRURGICAL FACULTY  
OF STATE OF MARYLAND

A scientific program of educational value and interest has been arranged for the 163rd Annual Meeting of the Maryland State Medical Society on Wednesday, Thursday, and Friday, April 26, 27, and 28. All scientific sessions will be held at the Alcazar, Cathedral and Madison Streets, Baltimore.

SCIENTIFIC PROGRAM

The Alcazar

Wednesday, April 26, 1961

- 2:15 p.m. Viral Infections of the Respiratory Tract. A panel discussion.  
*Moderator*—**Harry M. Rose, M.D.**, John E. Borne Professor of Medical and Surgical Research, College of Physicians and Surgeons, Columbia University, New York.  
*Participants*—**William S. Jordan, Jr., M.D.**, Professor and Chairman, Department of Preventive Medicine, University of Virginia, School of Medicine, Charlottesville.  
**Robert H. Parrott, M.D.**, Physician-in-Chief and Director of the Research Foundation, Children's Hospital of District of Columbia.
- 4:15 p.m. Chemotherapy of the Solid Tumors. J. M. T. Finney Fund Lecture.  
**George E. Moore, M.D.**, Director, Roswell Park Memorial Institute, Buffalo.

Wednesday Evening

- 8:30 p.m. Malpractice Actions Against Doctors. A medicolegal symposium.  
*Moderator*—**Russell S. Fisher, M.D.**, Chief Medical Examiner of State of Maryland, and Professor of Forensic Pathology, University of Maryland.  
*Participants*—**G. C. A. Anderson, Esq.**, Attorney for Medical and Chirurgical Faculty.  
**William D. Macmillan, Sr., Esq.**, Former President of Bar Association of Baltimore City.

Thursday, April 27, 1961

- 9:30 a.m. Management of Congestive Heart Failure. A panel discussion.  
*Moderator*—**T. S. Danowski, M.D.**, Professor of Research Medicine, University of Pittsburgh School of Medicine.

*Participants*—**John H. Moyer, M.D.**, Professor of Medicine and Chairman of Department of Internal Medicine, Hahnemann Medical College, Philadelphia.

**John S. Stauffer, M.D.**, Research Assistant Professor in Department of Surgery (Cardiopulmonary), University of Maryland School of Medicine.

- ▶ 11:00 a.m. Medical Activities Within the Department of Defense. I. Ridgeway Trimble Fund Lecture. **Frank B. Berry, M.D.**, Assistant Secretary of Defense for Health and Medical Affairs, Washington, D. C.
- ▶ 12:30 p.m. **ROUND TABLE LUNCHEON.** Park Plaza Hotel, Charles and Madison Streets. There will be 25 round table discussions, with moderators, on various phases of medicine. A list of these will be mailed to all members early in April. All physicians are invited to make early reservations for this popular session.
- ▶ 2:15 p.m. Stay Alive. **Perry S. MacNeal, M.D.**, Physician to the Benjamin Franklin Clinic of the Pennsylvania Hospital and Associate Professor of Clinical Medicine, University of Pennsylvania School of Medicine.
- ▶ 3:15 p.m. Use of Radioisotopes in Medical Diagnosis. Harvey Grant Beck Memorial Lecture. **Merrill A. Bender, M.D.**, Chief, Department of Nuclear Medicine, Roswell Park Memorial Institute, Buffalo.
- ▶ 4:15 p.m. Problems in the Management of Obesity. A panel discussion.

*Moderator*—**Thomas B. Connor, M.D.**, Associate Professor of Medicine, and Head of Division of Endocrinology and Metabolism, University of Maryland School of Medicine.

*Participants*—**Mrs. Eloise R. Trescher, B.S.**, Nutrition Consultant, Baltimore.

**Russell R. Monroe, M.D.**, Professor of Psychiatry, University of Maryland School of Medicine.

Thursday Evening

7:15 P.M.

#### **PRESIDENTIAL DINNER—SHERATON BELVEDERE HOTEL**

- ▶ 6:15 p.m. Social Hour.
- ▶ 7:15 p.m. Dinner. All physicians, their wives and guests, are invited.
- ▶ 8:30 p.m. General Meeting.

**ALL** members are invited even though they do not attend the dinner.

Friday, April 28, 1961

- ▶ 9:30 a.m. Endocrine Therapy for Gynecologic Disorders. **Allan C. Barnes, M.D.**, Professor and Chairman, Department of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine.

- 10:30 a.m. The Public Image of Medicine. A panel discussion.  
*Moderator*—**William S. Stone, M.D.**, Dean, University of Maryland School of Medicine.  
*Participants*—**Richard O. Cannon, M.D.**, Director, Vanderbilt University Hospital, Nashville.  
**Russell B. Roth, M.D.**, Attending Urologist, St. Vincent Hospital, Erie, Pa., and Member of Council on Medical Service of the A.M.A.

### BUSINESS SESSIONS

- Wednesday, April 26, 1961. The Alcazar.
  - 9:00 a.m. The Council.
  - 9:30 a.m. House of Delegates.
  - Friday, April 28, 1961. Faculty Building, 1211 Cathedral Street.
  - 2:00 p.m. House of Delegates.
- New Council will meet immediately following.

### SCIENTIFIC EXHIBITS

Scientific exhibits worthy of study will be on display in the Blue Room of the Alcazar.

Coffee, Coca-Cola, Pepsi-Cola and Seven-Up will be served to those attending the meetings.

### AUXILIARY LUNCHEON

The Woman's Auxiliary to the Medical and Chirurgical Faculty on Wednesday, April 26, will have its annual luncheon at the Sheraton Belvedere. All members of the Faculty, their wives and guests are invited. Many other attractive features have been planned by the Auxiliary for the ladies on April 26 and 27.

### READ and RELAX

The Library of the Medical and Chirurgical Faculty will have set up in the Blue Room of the Alcazar an area where physicians may browse through, read, borrow, and return books.

This Annual Meeting program has been arranged by the Committee on Scientific Work and Arrangements—**William E. Grose, M.D.**, *Chairman*, **Houston S. Everett, M.D.**, **J. Douglas Lockard, M.D.**, **Joseph B. Workman, M.D.**, and **William Carl Ebeling, M.D.**

### TECHNICAL EXHIBITS

Wednesday, April 26—10:00 a.m. to 5:00 p.m.  
 Thursday, April 27— 9:00 a.m. to 5:30 p.m.  
 Friday, April 28— 9:00 a.m. to 1:00 p.m.  
 The Ballroom of the Alcazar will be filled with technical exhibits, which will prove profitable and time-saving. Allow time in your schedule to visit these exhibits.

### PLAN NOW TO ATTEND THE ANNUAL MEETING

Wednesday, Thursday, Friday, APRIL 26, 27, 28, 1961



John Sargeant  
Executive Secretary

# YOUR MEDICAL FACULTY AT WORK

The Executive Committee and Council of the Medical and Chirurgical Faculty of the State of Maryland met on the dates shown and took the actions shown:

## **Executive Committee, December 1, 1960**

1. Discussed proposed Blue Shield Bylaw changes and stated they appeared to be satisfactory to the Faculty. These would provide for an increase in the Board membership from 12 to 21, 12 of whom would be physicians selected from a list suggested by the Council of the Faculty.

2. Discussed the Blue Cross and Hospital Council proposals, agreeing that it was necessary to call a special Council meeting to take specific actions on these proposals.

## **Executive Committee, December 11, 1960**

1. Agreed to defer the proposed increase in the Baltimore City Dental Society dues from \$3.00 to \$5.00, pending discussion with officials from this group.

2. Agreed to development of a "panel" of physicians for use under the Longshoremen's and Harbor Workers' Compensation Act.

3. Agreed to meet with representatives of the American Physical Therapy Association, Maryland Chapter, at a future date to discuss mutual problems.

4. Approved the revised change in the Narcotic Law, which had been agreed to by the House of Delegates at the Semi-annual meeting.

5. Agreed to transfer Blue Cross group coverage of the Faculty employees to the \$50.00 deductible plan.

## **Council, December 11, 1960**

1. Discussed the proposed report to the Insurance Commissioner in connection with Hospital Utilization as developed by the Physician/Hospital/Blue Cross Conference Committee, together with the Faculty's minority report. It also authorized a letter with pertinent material to be dispatched to the membership over the president's name.

2. Authorized the president to be spokesman for the Faculty in the event any questions are raised on these reports.

## **Executive Committee, January 12, 1961**

1. Approved the 1961 budget for recommendation to the Council.

2. Authorized a letter of congratulation to the former attorney-general on his elevation to judgeship.

3. Modified slightly the present method of advising components on grievance case handling.

4. Went on record as opposing any homeopathic licensing bill that may be

introduced into the 1961 General Assembly.

5. Referred to the Corporate Practice of Medicine Committee, the question of ECFMG certification and its effect on hospital intern and residency personnel use in accident rooms.

6. Authorized a meeting with Steelworkers' Union representatives to discuss the Blue Steel program, if such representatives wish to meet with Faculty representatives.

7. Made recommendations for Council action on Blue Cross and Blue Shield Board and other appointments.

8. Heard a representative of the Maryland Radiological Society discuss the recent Physician/Hospital/Blue Cross Conference Committee activity.

#### **Council, January 17, 1961**

1. Observed a moment of silence in memory of Maurice C. Pincoffs, M.D.

2. Agreed to invite incoming councilors to the remaining 1960-61 Council meetings as observers without vote.

3. Ratified legal defense for members of the Faculty.

4. Heard of settlement of legal cases on Faculty members.

5. Adopted the 1961 budget.

6. Authorized the following appointments to the Blue Cross Board for a three year term:

Thurston Harrison, M.D., Easton  
William Lynn, M.D., Baltimore  
Osborne Christensen, M.D., Salisbury

7. Authorized the following appointments to Blue Shield Board and committees:

Blue Shield Board:

Bernard W. Sollod, M.D., Dundalk

Henry C. Briele, M.D., Salisbury  
James G. Arnold, M.D., Baltimore  
Charles N. Davidson, M.D., Baltimore

Medical Relations Committee:

Deonis Lupo, M.D., Baltimore  
William V. Lovitt, Jr., M.D., Baltimore  
John C. Hyle, M.D., Baltimore

Reference and Appeals Committee:

Webster H. Brown, M.D., Baltimore  
Samuel M. Jacobson, M.D., Annapolis  
F. Ford Loker, M.D., Baltimore  
Edmond J. McDonnell, M.D., Baltimore  
R. S. Stauffer, M.D., Hagerstown  
John F. Hogan, Jr., M.D., Baltimore  
Kent E. Robinson, M.D., Baltimore  
John E. Savage, M.D., Baltimore  
J. Elliott Levi, M.D., Baltimore

8. Authorized the Executive Committee to name substitutes if any of the above did not wish to serve in the capacity selected.

9. Heard a Legislative Committee report and adopted a policy in opposition to an organized "National Political Action Committee" of the American Medical Association.

10. Adopted a proposed Workmen's Compensation Fee Schedule for transmission to the Workmen's Compensation Commissioner.

11. Approved a newly written constitution and bylaws for transmission to the House of Delegates for action in April, 1961.

12. Reaffirmed the restrictions adopted by the Council some time ago dealing with payment by Blue Steel and Blue Shield for diagnostic x-rays.

13. Approved the combined committee report and referred it to the House of Delegates for action.

14. Heard letters from Paul Cohen, M.D., and Thomas B. Turner, M.D., regarding the statement "Doctors—Hos-

pitals—and Patients” and approved appropriate replies to them. Also heard a letter from the Maryland Academy of General Practice indicating its approval of the paper in its “broad general principles.”

15. Heard a report from the Executive Committee regarding the negotiations of the Physician/Hospital/Blue Cross Conference Committee.

### INTERNAL MEDICINE MEETING

The first joint meeting for 1961 of the Section of Internal Medicine of the Baltimore City Medical Society and the Maryland Society of Internal Medicine will be held Monday, March 20, at 8:15 p.m. in Osler Hall, 1211 Cathedral Street.

**HERBERT G. LANGFORD, M.D.**

Associate Professor of Medicine  
and Chief of the Endocrine and Hypertension  
Division

University of Mississippi School of Medicine  
Jackson, Mississippi  
will speak on

### AN INVESTIGATOR'S VIEW OF CLINICAL HYPERTENSION

**JOHN EAGER HOWARD, M.D.**

Professor of Medicine  
The Johns Hopkins University School  
of Medicine

**SAMUEL T. R. REVELL, M.D.**

Professor of Medicine  
and Head of Division of Hypertension—  
Renal Disease  
University of Maryland School of Medicine  
Discussants

### Questions and Answers

The Section of Internal Medicine of the Baltimore City Medical Society will hold its annual business meeting and election of officers after the scientific program.

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# THE POLYCYSTIC OVARY SYNDROME

Robert B. Greenblatt, M.D.

The polycystic ovary, or Stein-Leventhal syndrome, may be regarded as a form of hyperovarianism.

Evidence has been presented to show that the so-called "mechanical barrier" to ovulation resulting from sclerotic thickening of the capsule is, in all probability, an erroneous concept.

Pituitary hypersecretion of either FSH or LH as a causative factor in the polycystic ovary syndrome has not been satisfactorily substantiated.



Evidence has been brought forward to support the contention that inherent ovarian hyperresponsiveness to pituitary gonadotrophins, leading to increased ovarian mass, may be the responsible factor in the syndrome of polycystic ovaries.

The potential tissue capacity of the ovary for hormonal responsiveness may be greatly enhanced because of increased sensitivity to FSH and/or an inherent enzymatic disorder of the ovary leading to disturbed steroid synthesis by the ovary.

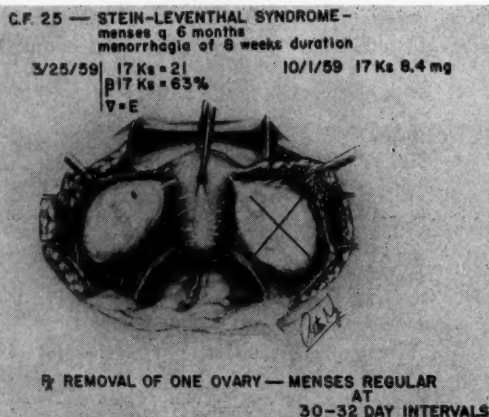


Figure 1

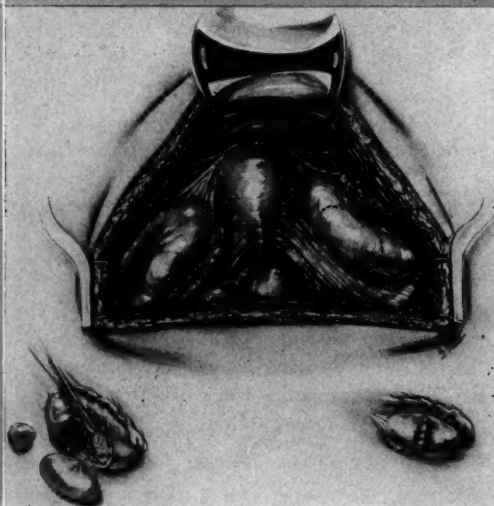
Removal of one ovary in a patient with the Stein-Leventhal syndrome resulted in occurrence of cyclic ovulatory menses in spite of thickened capsule of the remaining ovary.

Figure 2

Typical large pale ovaries with a fresh corpus luteum were found at laparotomy in a patient with typical Stein-Leventhal syndrome.

Figure 3

Compensatory elongation of ovary in patient with Stein-Leventhal syndrome in whom the contralateral ovary had been previously removed.





MUCH HAS BEEN written about the polycystic ovary syndrome, but little is really known about its etiology. Stein and Leventhal, in 1935, described a series of cases with amenorrhea, obesity, hirsutism, and infertility, associated with bilaterally polycystic ovaries (1). The collation of signs and symptoms, means for diagnosis, and wedge resection of the ovaries as the ideal mode of therapy established the syndrome which has borne their names. It is not generally appreciated that the patient with this disorder may complain of menorrhagia rather than amenorrhea, may be of normal habitus rather than obese, and need not be hirsute. Furthermore, infertility may be relative or secondary, in that one or more conceptions may have occurred in the past.

The histopathology of the ovaries has been described, but unanimity is lacking as to interpretation of the histopathologic findings (2). In recent years, interest in this syndrome has been renewed and attempts to elucidate its etiology are being made. The purpose of this paper is to present some observations which may throw light on the etiology of this enigmatic endocrinopathy and to comment on some current questions about the nature of this disturbance.

#### **QUESTION 1. Does the syndrome result because of the fibrotic thickening of the capsule of the ovary?**

The opinion has long been held that follicular rupture and ovulation cannot occur because the thick sclerotic tunica acts as a mechanical barrier (3,4). For this reason, operations for stripping of the capsule or technics for ovarian eversion have been suggested (5). Some feel that ovulation takes place after wedge resection along the weakened approximated edges of the ovary. The following experiment was undertaken to disprove the "mechanical barrier" concept.

##### **CASE 1**

V.F., age 25, complained of uterine bleeding of eight weeks duration. She was somewhat obese, moderately hirsute, and had good breast development. A history was obtained of functional amenorrhea with spontaneous

Presented at the 162nd Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Baltimore, April 21, 1960.

Studies on the polycystic ovary syndrome were aided by a grant from Merck, Sharp and Dohme, Inc.

From the Department of Endocrinology, Medical College of Georgia, Augusta, Georgia.

menses occurring about once every six months. Bilaterally enlarged ovaries were readily palpable on pelvic examination. An endometrial biopsy obtained by suction curettage revealed a proliferative endometrium. Her urinary 17-ketosteroids were elevated to 21 mg. per 24 hours (normal value for our laboratory is 6 to 13 mg. for females). The beta fraction of the 17-ketosteroids was assayed at 63 per cent, normal values in our laboratory being under 40 per cent.

A laparotomy was performed, and greatly enlarged ovaries with a thick white glistening tunica were noted. Because of the classical appearance of the ovaries and the apparent marked thickness of the ovarian capsule, it was decided to remove only one ovary and leave the other untouched (fig. 1).

The pathologist, Menard Ihnen, M.D., reported as follows: "Specimen labeled 'right ovary.' The external surface of the ovary is white with numerous small cysts being present underneath. The ovary measures 5x3x3 cm. On section numerous subcortical cysts 4 x 4 mm. in diameter are present. The more central portion of the ovary appears white and of homogenous texture. Microscopically, sections show subcortical follicular cysts with no recent corpus albicans present. The tunica is thicker than is normally seen. The theca stains with fat stain."

The patient has menstruated with regularity at 30 to 32 day intervals since surgical interference. She is now experiencing premenstrual molimina, and an endometrial biopsy obtained one week before the expected onset of menses revealed an ovulatory secretory endometrium. The urinary 17-ketosteroid assay performed some six months after surgery showed a value of 8.4 mg. per 24 hours. During the following 15 months of observation there has been no menorrhagia or amenorrhea.

It would appear from observations made in this case that ovulation can occur with regularity from an ovary with a thickened tunica.

#### **QUESTION 2. Does spontaneous ovulation ever occur in patients with Stein-Leventhal syndrome?**

The impression held by many is that ovulation never occurs in these patients, hence their menstrual disorders and infertility. The occasional occurrence of ovulation has been noted after surgery for appendicitis or other pelvic surgery. Possibly the stress and anxiety associated with a major surgical procedure precipitated the occurrence of ovulation. The following case is presented to illustrate this point.

##### **CASE 2**

A 32-year-old woman returned to see the author several years after her marriage with the complaint of infertility. She had been seen from time to time between the ages of 16 and 25 years because of increasing hypertrichosis and infrequent bleeding episodes. A diagnosis of Stein-Leventhal syndrome was made because enlarged ovaries were palpable on pelvic examination.

In 1953, her 24 hour urinary hormone assays revealed less than 13 m.u. of gonadotrophins, while the 17-ketosteroids were elevated to 23.7 mg., and the 17-hydroxycorticoids showed the low value of 2.92 mg. per 24 hours.

In 1958, a diagnostic curettage and laparotomy were performed. Some nine months had elapsed since her last menstrual period. The typical elongated, enlarged ovaries with thick pearly capsules were found at laparotomy. In the left ovary, a fresh corpus luteum bulged the surface at the lateral extremity (fig. 2). Elliptical wedge resections were performed on each ovary. The characteristic histopathology was present in sections from each ovary. Aside from the fresh corpus luteum, no recent regressing corpora lutea or old corpora albicantes were seen, except for an old hyalinized corpus albicans in a section of the right ovary.

Ovulation may well have been related to the stress of the situation. It has been observed that the administration of ACTH, as well as of cortisone, has been followed by menstruation in amenorrheic females (6,7). Ovulation occurred in this patient in spite of the thick ovarian capsules noted at the time of surgery. Incidentally, the patient menstruated 48 hours after the operative procedure and has continued to have cyclic

ovulatory menses since that time, although conception has not occurred in the two years that have lapsed.

### QUESTION 3. Is the syndrome due to pituitary dysfunction resulting in increased FSH or LH secretion?

For a number of years the suggestion has been offered that the disorder might be caused by hypersecretion of pituitary gonadotrophins (8,9). FSH has been incriminated, as has LH. MacArthur and her colleagues have shown a slightly raised and persistently prolonged LH level in study of these patients (10). More recently, Keetal and coworkers administered a more or less purified form of FSH to normal women and to patients with Stein-Leventhal syndrome, obtaining markedly enlarged ovaries only in the latter (11). This suggested to them that a hypersecretion of FSH might be responsible for the disorder; however, urinary assays of total gonadotrophins performed by accepted methods have



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continued to reveal normal gonadotrophin values in these cases.

One possibility to consider is that the syndrome is due neither to increased FSH nor LH but to an inherent responsiveness of the ovaries to endogenous gonadotrophins, particularly FSH. It is my belief that the potential tissue capacity for responsiveness to this trophic hormone is greatly enhanced in this disorder, resulting in the stimulation of literally hundreds of Graafian follicles instead of only a chosen few at any one time. The other tissue components of the ovary are also hyperresponsive. This concept should not be too difficult to accept, for it parallels that of target gland hyperresponsiveness in other endocrinopathies. The adrenal hyperplasia seen in Cushing's diseases is not caused by excessive endogenous ACTH (12,13,14); nevertheless, excess administration of ACTH will induce adrenal hyperplasia. A similar example may be drawn in Graves' disease. Although the cause of hyperthyroidism is not known (15), it does not appear to be caused by excessive production of pituitary

thyrotropin (TSH), though excessive administration of TSH can produce signs of thyrotoxicosis. The administration of gonadotrophins to humans (particularly FSH, pituitary synergist with human chorionic gonadotrophin, pregnant mare serum, and human chorionic gonadotrophin) may cause severe enlargement of the ovary, follicular cysts, and theca cell hypertrophy (16). The removal of a greater part of the adrenal in Cushing's disease, the thyroid in Graves' disease, and the ovaries in polycystic ovary syndrome is followed by restitution toward normalcy because of a reduction in target gland mass.

It is my opinion that the Stein-Leventhal syndrome is a form of hyperovarianism which is most likely caused by increased responsiveness of the ovaries to endogenous gonadotrophins. The gonadotrophin responsible for increased ovarian mass is probably FSH, as shown by Keetal and coworkers (11). This would result in a lesser amount of LH per unit of ovarian mass, even though the LH levels may be stationary or slightly increased, and thus result in lack of ovulation.



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The reduction of ovarian mass, whether by ignipuncture, wedge resection, removal of one ovary, or x-radiation, would help to restore to the original level the available LH per unit of the ovarian mass and thus stimulate ovulation.

The following case history is significant (2).

#### CASE 3

G.A., a 32-year-old white woman, was first seen in November 1958 complaining of increasing menometrorrhagia and hirsutism. Menarche had occurred at age 14 with irregular menses from the outset. Because of menometrorrhagia, a left salpingo-oophorectomy had been performed when she was 20. The removed ovary was reported to be "2 to 3 times normal size and covered with cysts." After this operation, menses became regular, and the patient bore two children.

Within a year after the birth of the second child, however, irregular bleeding and hirsutism appeared, which became progressively worse until the time of admission four years later. Significant physical findings included hypertrichosis involving the chin, lip, and abdomen, normal sized clitoris, retroverted uterus, and a greatly enlarged and elongated ovary in the right adnexum. Urinary 17-ketosteroid excretion was 13.9 and 18.5 mg. per 24 hours on two consecutive days.

Since the patient lived far away and could not be followed closely, surgical treatment was elected. At operation, the left ovary was absent. The right ovary was enlarged and elongated to 2 to 3 times normal size and showed the typical polycystic change (fig. 3). A transverse wedge resection and coring out of the hilus was made. Since operation, the patient has had regular 28 day cycles, with ovulation occurring on the fourteenth day, and has had no further abnormal bleeding episodes. Hair growth has diminished slightly, and urinary 17-ketosteroid excretion has decreased to 8.8 mg. per 24 hours.

This patient exhibited relief of symptoms following removal of one ovary, which, however, was followed by a recurrence several years later. At a second operation 12 years later, the remaining ovary showed the typical polycystic change. Wedge resection proved successful in restoring normal ovulatory menstrual function and in decreasing hair growth. The temporary regression of symptoms following unilateral oophorectomy shows that simple decrease of ovarian mass may be beneficial. This effect is not permanent, however, since the remaining ovary may ultimately undergo hypertrophy with a return of symptoms.

Wedge resection has been observed to cause temporary benefits, with a recurrence of the syndrome taking place, in some instances, one to two years later. In these cases, an insufficient amount of ovarian tissue may have been removed. It is well known that the glands of internal secretion have a faculty for regenerative growth, a fact

which is particularly true of the adrenal and thyroid glands.

#### QUESTION 4. Why do certain cases fail to respond to wedge resection but respond to corticoid therapy?

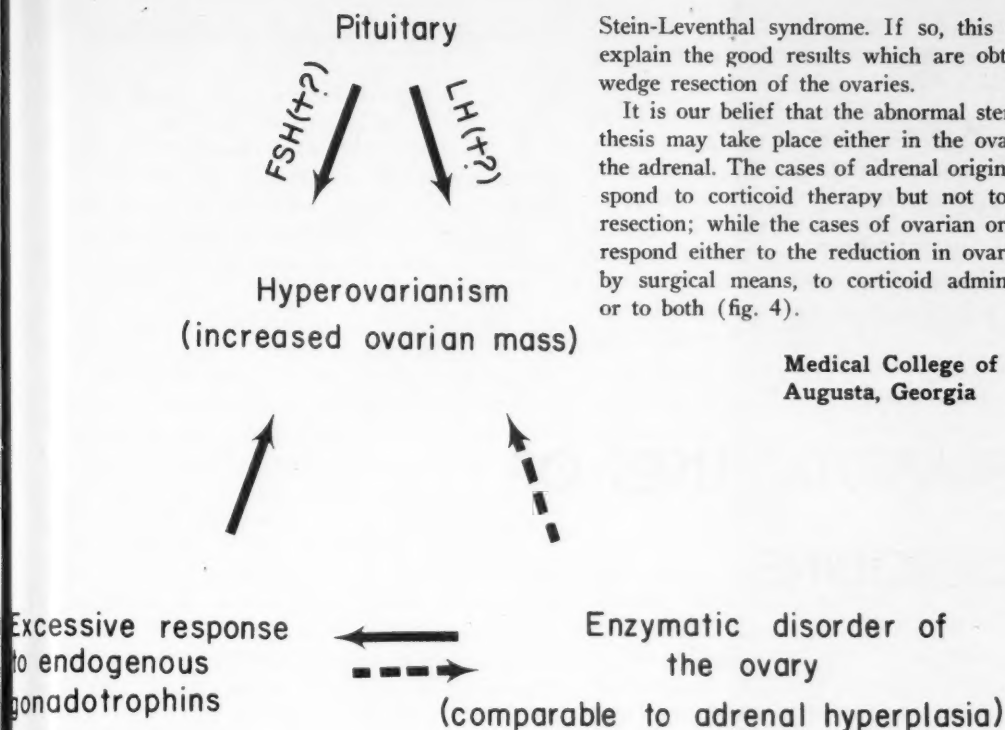
The use of corticoids in treating women with follicular phase defects was first recommended by Seegar-Jones and her associates (17). At the same time, we at the Medical College of Georgia, while treating amenorrheic hirsute females with cortisone, noted the induction of ovulatory menses in many instances (18).

Although the corticoids have received widespread exploitation for treatment of this condition since the original reports appeared, their mode of action is still not clearly understood. It may be that the suppression of 17-ketosteroids and other steroids of the adrenal gland removes some of the LH inhibitors, resulting in a greater amount of LH per unit of ovarian mass, a situation which is comparable to reduction of ovarian mass with respect to LH. Another theory which has been advanced is that the corticoids act primarily on the hypothalamus, allowing improvement in the hypothalamico-pituitary-ovarian axis. These hypotheses cannot be equated with a concept of hyperresponsiveness of the ovaries to normal levels of endogenous gonadotrophins.

Continuing in the realm of speculation, it might be asserted that corticoids lessen the sensitivity of ovarian tissue to endogenous gonadotrophins, permitting a more orderly pituitary-ovarian relationship to take place. This, in effect, would be equivalent to a reduction of ovarian mass.

Another possibility worthy of consideration is that of an inherent abnormality of the enzyme system in the ovary which is modified by corticoid therapy. Abnormalities in steroid synthesis have been found in the Stein-Leventhal syndrome (19), and it was recently intimated that noteworthy differences appeared in certain 21-deoxysteroid metabolites in the urine of patients with Stein-Leventhal syndrome and congenital adrenal hyperplasia. In the former, urinary excretion of delta-5-pregnenetriol and pregnanetriolone were elevated; in the latter, these same two excretory products, as well as pregnanetriol, were increased. It was thus deduced that adrenal dysfunction might be the underlying cause in





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Figure 4

Schematic presentation of hypothesis of pathogenesis of the Stein-Leventhal syndrome.

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A discussion  
of the clinical uses  
of radioactive iodine  
in treating  
thyroid cancer  
and hyperthyroidism

## THERAPEUTIC USES OF RADIOIODINE

Samuel P. Asper, Jr., M.D., and Joseph E. Rall, M.D.

DR. ASPER: Radioiodine is an unusual isotope in that it has a halflife of eight days, which is neither too short nor too long. By this I mean that radioiodine can be shipped from the source where it is prepared, usually at Oak Ridge, Tennessee; and when we get it within 24 hours, it has not deteriorated significantly.

In addition, this halflife of eight days means that within a month or two after a therapeutic dose is given, the patient no longer has any significant quantity of radioactive iodine remaining in his body. This is, of course, important.

Also significant is the fact that radioactive iodine ( $I^{131}$ ) has certain unusual characteristics of physical radiation. Most of its radiation is beta

emanation, which has a rather poor penetration in tissues of only about two millimeters. Yet, about 15 per cent of the radiation from iodine is gamma radiation, which has a high penetration. It will go right through body tissues, which means that radioactive iodine can be followed easily by external counting over the thyroid or over other parts of the body.

Since most of the radiation is in poorly penetrating beta radiation, thyroid tissue can be destroyed completely without damage to any nearby structures. In hyperthyroidism, for example, it is possible to ablate the thyroid gland without damaging the parathyroid glands or the vocal cords or the nerves or any other structures in the neck. With the strong penetration of gamma radiation; on the other hand, it is possible to search for and to find metastases, when they exist, in some patients with thyroid cancer.

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Presented at the 161st Annual Meeting of the Medical and Chirurgical Faculty of Maryland on April 16, 1959, Baltimore, Maryland.

## Radioiodine in Cancer of the Thyroid

DR. RALL: Only a small fraction of patients with carcinoma of the thyroid are suitable candidates for treatment with  $I^{131}$ . I think that most people who are interested in this type of treatment or in cancer of the thyroid gland generally have been lured on and enticed to further work by the occasional case which shows a brilliant result.

It might be worthwhile to review briefly the pathology of carcinoma of the thyroid. This gland is subject to the most diverse types of tumors, perhaps, of any tissue. The papillary carcinoma of the thyroid is such a slow growing entity that there are those—to the west—who feel it is virtually benign, a view which most of us on the East Coast cannot concur; but certainly ten and 20 years survival from inadequate surgery is not surprising. Carcinoma of the thyroid of the metastasizing struma type, which used to be known to the old pathologists as benign metastasizing struma, does not even look like carcinoma except that it may be found in the lungs or in the bone. This tumor is frequently compatible with a long survival. On the other hand, giant and spindle cell carcinoma of the thyroid is highly malignant. Of the patients I have seen, only one has survived longer than six months. This is, perhaps, one of the most anaplastic growths that one runs into.

The pathologic type of carcinoma is important, because a general correlation exists between the histologic appearance of a carcinoma of the thyroid and a chance that it will pick up iodine. If the carcinoma has follicles and makes thyroglobulin, which you see as colloid, it will pick up iodine. If it does not have follicles and does not seem to have any colloid, the chances are that it won't. One unfortunate factor is that a tremendous macropleomorphism occurs in this disease. If one looks at many sections and many metastases from the same tumor in the same individual, one may see areas of relative anaplasia in one lymph node, some preservation of the normal pattern in another, and a wild mixture of types in a third. One may look at a slide and say, "Ah, this is papillary carcinoma of the thyroid," but that does not mean that the tissue you did not section is also papillary carcinoma of the thyroid.

These considerations, therefore, must be

taken into account in the selection of patients for attempted treatment with radioiodine. Of course, surgical therapy of carcinoma of the thyroid is the first consideration. I do not think there is any serious argument with this statement. If an individual with carcinoma of the thyroid is operable, he should be operated. There is reason to believe, I might add, that in most carcinomas of the thyroid, a radical dissection on the side where the carcinoma is located is desirable; and total thyroidectomy, including the removal of the other lobe, may be a desirable procedure.

So, when we talk about  $I^{131}$ , we are referring only to patients with a metastatic disease which is inoperable by courageous surgeons. What fraction of these inoperable patients will pick up iodine? A tracer dose will show whether there is uptake, if careful scanning of the areas of metastases, suspected or likely, is investigated. A small number perhaps 10 per cent of the people thus examined, will show sufficient uptake in their carcinoma to make a therapy dose of radioiodine at that time advisable. If some uptake occurs and the histologic pattern is at all favorable, we think that thyroidectomy should be completed if it has not already been done. This can be done either surgically, depending upon the exact situation of the patient, or with something of the order of a 30 or 40 millicurie dose of  $I^{131}$ . After a thyroidectomy, the patient is allowed to become myxedematous for a period of six weeks to three months. Repeat tracer studies are done; if the patients have been selected carefully, perhaps a third or a half of them will show enough of an increase in uptake to make therapy with radioiodine advisable. If this is not effective, then we like to give them a trial with an antithyroid drug; at the moment we prefer methimazole (Tapazole®) in large doses for six to eight weeks. This usually increases the myxedema, and the patients are uncomfortable but not desperate. Three days after cessation of the drug, another tracer study is done. By this time, about a third or so of the remaining patients will then show enough of an uptake to make therapy advisable.

The question of dosage calculation is perhaps the most perplexing part of all. The complications that have arisen might be noted. I have seen one death from  $I^{131}$ , which occurred a long time ago, in a woman who received repeated doses of  $I^{131}$  over the course of about two years, amounting to

well over a curie. She developed a complete aplastic anemia which terminated fatally in a few months, certainly a direct radiation death. No more have occurred since that time, to my knowledge.

As far as the bone marrow is concerned, another possibility arises; that is leukemia. What are the chances of that? We have seen one case of leukemia out of about 100 patients with carcinoma of the thyroid treated with large doses of radioiodine. If one takes Lewis's figure, which is that one gets  $2 \times 10^{-6}$  chances of developing leukemia per year per r, and assumes that all our patients received on the average 1000 r (in multiple doses), which seems reasonable, one would expect a 50 per cent chance over ten years of getting a single patient with leukemia; and we did. In the average patient receiving large doses of  $I^{131}$  and followed for 10 years, the chance of getting leukemia is about 0.5 per cent. The world literature has now, as I recall, about nine cases of leukemia after  $I^{131}$  treatment of carcinoma of the thyroid. We tried to make some preliminary calculations on what population this represented, what dosages were given, and what time had elapsed; and our figures agreed within an order of magnitude with Lewis's figures.

The third complication, and one of the most distressing ones, is pulmonary fibrosis. An astonishingly large number of patients with carcinoma of the thyroid have pulmonary metastases, some of whom respond dramatically to  $I^{131}$ . In giving a large dose of radioiodine, one can get the same result as with x-ray when treating a patient with carcinoma of the breast with, perhaps, too generous external radiation; one can get pulmonary fibrosis. We've had two cases like this, and the difference is that the fibrosis and pneumonitis occurred relatively rapidly, ending with demise within four months of the time of radioiodine. This caught us by surprise, because we had treated quite a few patients with pulmonary metastases before happening upon these two unfortunate women. In reviewing these cases, it appeared that their pulmonary metastases were somewhat different. They were more diffuse and finer. Apparently, we were getting really excellent cross-irradiation of all the normal tissues.

We have reviewed all our cases and find that across the board we have gotten something on the order of 20 to 30 per cent x-ray evidence of pulmonary fibrosis in our patients. So far, none of

these others has been serious enough to really worry the patient or to worry us a great deal. The problem is, first, to restrict the dosage in these patients with fine military metastases scattered throughout the lung. We correlated the dosage of radiation to the chest expressed as millicuries deposited there the first day of the therapeutic dose of  $I^{131}$  against pulmonary damage in 15 patients. It became apparent that little damage was done in any patient at a chest dose of  $I^{131}$  below 100 millicuries and that more than 125 millicuries were required to produce serious damage. So, as a rule of thumb we try to deposit less than 125 millicuries in the chests of patients with diffuse pulmonary metastases.

In the two cases we observed of radiation pneumonitis, the pathologic findings were of some interest. Early fibrosis, cellular infiltration, and, in particular, deposition of hyaline-like material in and around the small bronchioles and aveoli were seen. Probably this hyaline material prevented adequate oxygen exchange. There is, therefore, one upper limit to any dose of  $I^{131}$ ; that is, in patients with military metastases in the lungs, the dose deposited in the chest should be less than 125 millicuries.

How about the other problems? The problem of aplastic anemia and agranulocytosis is a real one. We have found it necessary to make a rather complicated appraisal of how the individual patient metabolizes  $I^{131}$  before administering a therapy dose. Some individuals retain the iodine in their tumor for quite a long time and discharge little into their blood stream; others discharge a lot of iodine into the blood stream as  $PBI^{131}$ , which radiates their bone marrow and lymph nodes and can cause serious damage to blood forming organs. After estimating how serious this will be, we guide our dosage accordingly. We had, for example, a patient in whom we have restricted a therapy dose to 100 millicuries because of the rapid turnover causing an unusually large amount of blood radiation.

We had another patient with a small uptake and a relatively large tumor, who was almost terminal and in whom we felt obliged to try a last and desperate therapy. We gave her 600 millicuries of  $I^{131}$ . She showed almost what we expected: a transient leucopenia, transient thrombocytopenia, and she recovered quite satisfactorily. Interestingly enough, and gratifying, she showed some improvement in her carcinoma.



Nevertheless, administration of doses approaching such magnitude requires a most careful calculation beforehand as to what the effect will be. Furthermore, such a situation is uncommon; I don't think we have used a dose that large in the last three or four years.

These, then, are the criteria: first, to give as much as you can; second, to restrict the dose to the amount that is calculated not to seriously disturb platelet and leukocyte formation, which is of the order of about three to four hundred rads. to the blood. I shall not go through the equation that we use to calculate this. Finally, in cases of pulmonary metastasis, we further restrict the dose on the basis of trying to deposit less than 125 millicuries in the lungs.

What are the results of treatment according to these plans? When results of treatment were reviewed at Memorial Hospital in 1956, it was found that 33 or 45 patients so treated had shown some objective improvement. Seventeen of these patients had sustained improvement in this disease. Our results subsequent to this report at Bethesda have shown similar data in a smaller series of patients. It is important to note, however, that these patients were critically selected, and the results were not what we would find if patients were treated irrespective of uptake. If an individual with metastatic carcinoma of the thyroid showing good uptake of  $I^{131}$  is treated, the therapy dose must be related to the mass of tumor. If the tumor is too large, it may be impossible to administer enough  $I^{131}$  to deliver adequate radiation. In such cases, surgical resection of any resectable tumor seems advisable.

We have also acquired enough experience to temper our enthusiasm. One of our more dramatic cases of cancer of the thyroid treated with  $I^{131}$  showed dramatic improvement in six weeks; in a year, the tumor (which had been located mainly in the chest) was no longer in evidence. This patient was asymptomatic and, by any criteria free, of tumor for five years. Five and one-half years after treatment, a metastases reappeared; one cannot, therefore, ever speak of "cures."

Recently, desiccated thyroid or triiodothyronine has been advocated for the treatment of metastatic thyroid cancer. Although it is true that occasionally hypothyroidism stimulates growth of tumors of the thyroid, it has been rare in our experience

to see regression of cancer of the thyroid subsequent to the production of drug induced hyperthyroidism. We have seen three subjects with hyperthyroidism and metastatic cancer of the thyroid in whom the tumor itself produced excessive thyroid hormone. These cases, unusual as they are, respond quite favorably to treatment with  $I^{131}$ . Of some interest is the continued growth of these tumors during hyperthyroidism.

In summary, radioiodine occasionally is of great help, therapeutically, in carcinoma of the thyroid, and in such instances it certainly should be used. Its use is quite complicated and should be reviewed carefully with respect to giving as large a dose as possible while, at the same time, avoiding the twin possibilities of damage to blood forming organs and damage to normal lung tissue.

### Radioiodine in Hyperthyroidism

DR. ASPER: Although radioactive iodine is effective in only a small number of patients with carcinoma of the thyroid, there is no reason why it should not be effective in virtually all patients suffering from hyperthyroidism. In rare instances, with a patient who has had iodide recently or is on iodide at the time of receiving a therapeutic dose, there may be no effect because the body is so saturated with iodine that the thyroid had no affinity for the radioiodine. You can well appreciate the fact that in hyperthyroidism the thyroid gland has a high affinity for iodine and that radioactive iodine should ablate the thyroid and bring about an improvement; and indeed it does in at least 90 per cent of all patients treated.

So effective is this treatment that you might ask why it is not used for all patients with hyperthyroidism. In some places it is, but in our own experience, we have tended to be rather conservative. About one-third of the thyrotoxic patients seen in Johns Hopkins Hospital in the past ten years we have treated with radioactive iodine; the others have been treated with subtotal thyroidectomy or with long term antithyroid drug treatment.

I am sure, however, that for some patients radioactive iodine is the treatment of choice. In the patient over 50 who has hyperthyroidism, especially in those with any significant degree of cardiac involvement, radioactive iodine works exceptionally well because the patient is not sub-

jected to a serious surgical procedure. The thyroid gland is ablated slowly with radioiodine.

In the younger individual, the thyrotoxic patient of 20 or 25, perhaps some other form of treatment, such as long term antithyroid drug therapy or subtotal thyroidectomy, is indicated because we do not yet know what the late effects of radiation may be in these patients. Patients treated before the war with iodine obtained from the cyclotron at the Massachusetts Institute of Technology have not developed carcinoma of the thyroid or other complications; nor have any significant complications been found among those treated since the war. On the other hand, the late radiation effects might take 20 or 30 or even 50 years to appear. For this reason, I think that a conservative course is indicated until we know what, if any, these late effects may be.

In the young individual who has hyperthyroidism following a previous subtotal thyroidectomy and in whom the mass of regenerated thyroid tissue is small, radioactive iodine can be used, however, because only a small dose—three or four or, at the most, five millicuries—would be required.

Most patients with hyperthyroidism are successfully treated with one dose of radioiodine. Overall figures from many different clinics show that two-thirds of the patients with hyperthyroidism are successfully returned to a normal thyroid status with a single dose. Of the remaining third, each dose subsequently will cure two-thirds of the patients. Obviously, then, a few patients may require as many as seven or eight doses, but only a third will require more than one.

The dose for most hyperthyroid patients is between six and ten millicuries, but there may be wide variations in this. We had one patient who developed hypothyroidism after receiving a dose of only two millicuries; on the other hand, occasional patients cannot be brought under control with total doses as high as 40 millicuries.

In some clinics, complicated formulae are used to calculate the dose of radioiodine to be given to the patient. Such formulae take into consideration the size of the thyroid gland, the rate at which the gland accumulates radioiodine, and the rate at which it puts out radioactive iodine. In our clinic, we generally rely on experience to guide us in determining what dose to give the

patient. By this I mean feeling the patient's thyroid gland, estimating its size, and having some general appreciation of the severity of thyrotoxicosis. Our overall experience has been neither better nor worse than that in clinics where calculation of dose is based on a formula. I think this can be explained by the fact that individual response varies considerably, there being some patients who respond much better, whose tissues are more susceptible to the damaging effect of radiation than that of others.

We mentioned earlier that radioiodine treatment in hyperthyroidism presents no significant complications. The only one of any importance, of course, is hypothyroidism, for if one gives too large a dose, the thyroid gland will be completely destroyed and myxedema will ensue. In some patients this is transient; in others it is permanent. Myxedema can, to be sure, be readily relieved by the administration of desiccated thyroid. The incidence of myxedema among hyperthyroid patients treated with radioiodine has been variously reported as being from 5 to 20 per cent.

In conclusion, radioiodine has now a well-defined role in the therapy of certain disorders of the thyroid.

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# EXPERIENCE WITH A DAY HOSPITAL UNIT

*At The Henry Phipps Psychiatric Clinic,  
Johns Hopkins Hospital*

William L. Webb, Jr., M.D.\*

SINCE NOVEMBER 1957, The Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital has operated a day hospital unit, modeled on the original Day Hospital Unit established by Dr. E. Cameron at the Allan Memorial Institute, Montreal, Canada, in 1946. Many of our operating concepts are derived from the recorded experience of that program.

Patients are admitted to the day hospital from 9 A.M. to 4:30 P.M. and return home in the evenings. They attend five days a week, remaining at home over the weekends. During the treatment period, they are extended the same facilities of the clinic which are available to patients on unaccompanied open ward status.

The patients are unaccompanied to and from their activities; there are no locked doors, and they are free to leave the ward at any time upon notification to the nurse. This policy is in keeping with the increasing liberation of psychiatric institutions toward an "open door" policy. It has been discovered in recent years, particularly with the advent of tranquilizing medications, that greater freedom for psychiatric patients results not in

chaos, but in improvement. Evidence is accumulating that traditional restraints and locked doors can impede recovery from mental illness. Aberrant behavior may be stabilized by group interaction with other patients, for the group provides the individual with the support needed to establish a less violent attitude toward his environment.

Operating upon this theory, the day hospital attempts to provide a maximally beneficial social milieu in which to carry out psychotherapy. Greatest emphasis is upon establishing meaningful group interaction among patients and staff. Since the patient remains "part time" in the community, the unit, by definition, maintains a strong liaison with the patient's family and others significant in his life. A social worker or staff physician counsels the patient's family, answers their questions, and gives them necessary emotional support during difficult periods in the patient's recovery. This creates a healthier home atmosphere, and during this time previously disruptive family patterns may be improved.

The patients meet in a pleasantly decorated ward which has a living room atmosphere. Since the patients do not remain for the night, they do not encounter the usual institutional decor of hospital beds, treatment trays, and bedpans.

\*Senior Assistant Resident, Henry Phipps Psychiatric Clinic.

| Diagnosis                         | Number     | Average Age | Sex       |           | Referral Source |           | Change in Clinical Status |            | Readmissions | Average Stay (Weeks) |
|-----------------------------------|------------|-------------|-----------|-----------|-----------------|-----------|---------------------------|------------|--------------|----------------------|
|                                   |            |             | M         | F         | Outside         | Inside    | Improved                  | Unimproved |              |                      |
| <b>I Psychosis</b>                |            |             |           |           |                 |           |                           |            |              |                      |
| A. Schizophrenic reaction         | 30         | 33          | 13        | 17        | 12              | 18        | 24                        | 6          | 3            | 6.0                  |
| 1. Undifferentiated               | 10         |             | 3         | 7         | 6               | 4         | 8                         | 2          | 0            | 5.1                  |
| 2. Paranoid                       | 17         |             | 9         | 8         | 5               | 12        | 13                        | 4          | 3            | 8.1                  |
| 3. Catatonic                      | 3          |             | 1         | 2         | 1               | 2         | 3                         | 0          | 0            | 5.0                  |
| B. Manic depressive reactions     | 13         | 49          | 7         | 6         | 5               | 8         | 10                        | 3          | 2            | 5.0                  |
| <b>II Neurotic reaction</b>       |            |             |           |           |                 |           |                           |            |              |                      |
| A. Anxiety                        | 23         | 33          | 12        | 11        | 11              | 12        | 21                        | 2          | 0            | 8.0                  |
| B. Depressive                     | 35         | 46          | 22        | 13        | 19              | 16        | 30                        | 5          | 3            | 5.9                  |
| C. Obsessive compulsive           | 4          | 40          | 2         | 2         | 2               | 2         | 4                         | 0          | 1            | 5.8                  |
| D. Conversion                     | 7          | 47          | 2         | 5         | 6               | 1         | 6                         | 1          | 1            | 6.3                  |
| E. Phobic                         | 3          | 30          | 0         | 3         | 1               | 2         | 3                         | 0          | 0            | 6.9                  |
| F. Dissociative                   | 3          | 24          | 0         | 3         | 1               | 2         | 3                         | 0          | 1            | 2.8                  |
| G. Psychoneurosis mixed           | 2          | 26          | 2         | 0         | 1               | 1         | 1                         | 1          | 0            | 6.4                  |
| <b>III Character disorders</b>    |            |             |           |           |                 |           |                           |            |              |                      |
| A. Drug addiction                 | 1          | 57          | 0         | 1         | 1               | 0         | 0                         | 1          | 0            | 1.6                  |
| B. Personality trait disturbance  | 2          | 26          | 1         | 1         | 1               | 1         | 2                         | 0          | 1            | 13.6                 |
| C. Dysocial reaction              | 1          | 15          | 1         | 0         | 1               | 0         | 1                         | 0          | 1            | 9.2                  |
| <b>IV Situational reactions</b>   |            |             |           |           |                 |           |                           |            |              |                      |
| A. Adolescent adjustment reaction | 8          | 16          | 1         | 7         | 8               | 0         | 4                         | 4          | 1            | 8.5                  |
| B. Adult situational reaction     | 2          | 32          | 0         | 2         | 1               | 1         | 2                         | 0          | 0            | 2.1                  |
| <b>TOTAL</b>                      | <b>134</b> |             | <b>63</b> | <b>71</b> | <b>70</b>       | <b>64</b> | <b>111</b>                | <b>23</b>  | <b>14</b>    |                      |

Their activities are supervised by a nurse in civilian dress, who is especially selected for her good judgment and ability in interpersonal relations. The nurse's administrative functions are kept at a minimum to allow her more time with the patients. The nurse and patients address each other by their first names, creating a setting in which an intimate, meaningful relationship develops, which gives the milieu its maximum therapeutic effect.

Every patient is under the care of a resident staff member, who works with the patient in individual psychotherapy several times a week. The patients also participate in the regularly scheduled clinic activities, including recreational therapy, occupational therapy, and clinic excursions. All in-patient treatments, including electroconvulsive therapy and drugs, are available to them.

As a group they are offered certain special activities. Each day begins with an informal discussion, over coffee, between the nurse and patients. During these sessions, the patients are free to discuss problems which have arisen during

their absence from the clinic. These sessions frequently produce useful information which may be transmitted to the resident physicians who see the patients in individual treatment. Other activities, in the past, have included socio-drama, dancing classes, excursions to places of public interest, and special mental health films. Considerable flexibility exists in the planning of these activities to meet the special needs of patients on the unit at any given time.

A member of the senior resident staff has been assigned as counselor and coordinator of ward activities. He conducts weekly discussion groups with the patients on topics they select and keeps active communications with the nurse on ward affairs.

The social service is always a useful adjunct to such a unit. Through such services, patients are placed in volunteer or regular work positions and are offered other resources for greater involvement in community life.

To date 134 patients have been treated in this unit. The accompanying table summarizes the number of patients in each diagnostic category,



the average age, the number of males and females, the referral source (either from outside or inside the clinic), the clinical status (improved or unimproved), the number of readmissions, and the average length of stay in the unit. Neurotic reactions have accounted for the largest number of admissions. Of these, anxiety and depressive reactions form the majority. Improvement with these groups has been exceptionally good. The ratio of neurotic admissions to psychotic admissions has been about two to one.

In general, these data reveal the Day Hospital to be useful in a wide range of psychiatric illnesses. The only restrictions apply to patients who represent serious suicidal threats or whose behavior is so disturbed as to be hazardous to themselves or to others. This leaves a large group of patients whose illness demands a partial relief from environmental stresses or whose therapy would be enhanced by the proper social milieu.

Nearly half of our referrals are in-patient transfers from more disturbed wards in the clinic. While the Day Hospital is a useful bridge in the transition from in-patient to out-patient status, our experience with patients directly referred from outside the hospital shows that the unit is also beneficial to this group. As physicians and psychiatrists in this area have become more familiar with the Day Hospital, they are referring more patients specifically for this program.

In general, our patients have represented a wide range in age and a more or less equal distribution of men and women. People with fairly wide age disparity function amazingly well in this setting; the elderly provide a stabilizing effect, while the younger members elevate the interest and morale of the group.

We have found the ideal ward population to be between 12 and 15 patients, about equally divided between men and women. The mixture of male and female patients on the same unit more nearly

approximates normal relationships outside the hospital and promotes better group interaction.

A notable advantage of this method of treatment is a substantial reduction of cost to patients and the hospital. Psychiatric hospitalization is a costly enterprise. Unlike hospitalization for acute illnesses, for which patients may be in and out in a matter of days, psychiatric hospitalization nearly always involves weeks or months. With the many problems of total patient care, extended hospitalization becomes expensive. The Day Unit, however, provides several money saving features. By eliminating extra shifts of nurses, decreasing the number of meals served, and caring for a greater number of patients per square unit of floor space, the hospital can offer this service at a substantially reduced cost to the patient. Currently the rates for the Day Hospital are about one-third lower per day than in-patient hospital rates. In certain cases, special programs of three days per week are available, which allows a longer stay at reduced costs.

The Maryland Blue Cross Plan covers 20 days of hospitalization for mental illness, and patients attending the Day Hospital are eligible for this coverage. Since the Day Hospital patient attends only five days a week, he is entitled to a week more of hospitalization than the patient who is hospitalized seven days a week. In these times of increased medical costs, these are important advances in patient care.

A review of our experience with this new concept in psychiatric hospitalization shows it to be a useful addition to our treatment facilities. Its emphasis on involvement of the community in psychiatric treatment points the way to future exploration and development of a good relationship between the psychiatric hospital and the community.

Henry Phipps Psychiatric Clinic  
The Johns Hopkins Hospital  
Baltimore 5, Maryland

**REMINDER—HOTEL ROOM RESERVATIONS**  
**APRIL 26, 27, and 28, 1961**

**Annual Meeting of Medical and Chirurgical Faculty**

A block of rooms has been set aside at the Sheraton Belvedere Hotel, Charles and Chase Streets, Baltimore, for those attending the Annual Meeting of the Medical and Chirurgical Faculty in April. The hotel will take your room reservations now. When making your reservation be sure to mention that you will be attending the Annual Meeting of the Faculty.

## THE GENERAL PRACTICING PHYSICIAN

*A social research study at Spring Grove State Hospital reveals a lack of contact and communication between the hospital and the general practicing physicians in the area it serves. Correction of the situation might result in benefits to patients and eventual savings to taxpayers.*

## AND THE STATE PSYCHIATRIC HOSPITAL

**I**N STUDIES of the preadmission and posthospital medical treatment of 100 Spring Grove State Hospital patients (1958-1959), a research social worker visited and interviewed a total of 55 physicians in general practice, 53 in Maryland and two in the District of Columbia. Data accumulated provide evidence of a lack of contact and communication between the state psychiatric hospital and community physicians concerning those patients for whom they share medical responsibility.

### Procedure and Population Samples

**A**S ONE FACET of a Comparative Drug Study (MY-2152) on the Spring Grove admission service, a survey was conducted of the medical treatment applied for and received by the

This study was supported by an N. I. M. H. Grant (MY-2152) administered by Friends of Psychiatric Research, Inc., of Baltimore.

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Albert A. Kurland, M.D.,\* and  
Gertrude L. Nilsson†

first 100 patients referred to the project, during the year prior to their admissions.

The research social worker interviewed the responsible relative of each patient. When the relative reported that the patient had a family physician, the social worker sent him a letter explaining the purpose of the study, requesting an appointment in his office, and stating she would call for his response.

The interview schedule concerned the physician's contacts with, and medical management of, his patient in the year closing with admission to Spring Grove. Spontaneous remarks volunteered about the hospital were also recorded.

The patients stayed on the project for periods ranging from two days to six weeks, and the following year a second study was conducted of the medical treatment they had received in or out of the hospital during the year following separation from the project. At this time, the social worker interviewed the patients, revisited the

physicians, and interviewed any other physicians in general practice with whom the patients reported having had contact. The second interview schedule included three questions on the theme of the physician's relations with Spring Grove:

1. *Have you had any contact with Spring Grove regarding your patient (or patients)?*
2. *Have you ever visited Spring Grove? If so, when?*
3. *Do you have any suggestions for implementing closer collaboration between hospital and physician for the benefit of patients?*

Unsolicited comments about the hospital again were recorded.

#### THE PATIENT SAMPLE

The patients were referred to the Comparative Drug Study by the admitting psychiatrists, selected for treatment with phenothiazine derivatives as indicated by such target symptoms as anxiety, agitation, hostile and destructive behavior, seclusiveness, and the general appearance of active disorder. Of their final diagnoses, 83 were psychoses, 73 of which were various types of the schizophrenic disorders.

In the group were 40 men and 60 women between the ages of 25 and 59. Fifty had had previous admissions to psychiatric hospitals, and 50 were first admissions. They came from Baltimore City and from Anne Arundel, Baltimore, Charles, Harford, Prince George's, and St. Mary's Counties. All five levels of "social position," as defined by Dr. August B. Hollingshead (1), were represented; but the two lowest "blue-collar" classes claimed about equal shares of nearly 80 per cent. Sixty-three of the patients were living in marital units at the time of their hospitalization.

Family physicians (a term accepted by all respondents without definition) were reported for 54 of the 100 patients.

#### THE PHYSICIAN SAMPLE

In the preadmission study, the social worker interviewed 47 physicians named as the family physicians of 53 patients. Although all were in

general practice, seven were identified with other medical specialties: four with internal medicine, two with surgery, and one with psychiatry and neurology. Geographically, they were located in or near the medical centers of Baltimore or the District of Columbia, none being more than 50 miles from Spring Grove.

Nine of these 47 were unavailable for the second interview, which took place approximately one year after the first. Three refused the second request because they had not seen their patients during the intervening period. For the other six the reasons were, respectively: death, extensive sick-leave for surgery, commitment to Spring Grove, transfer to another state, holiday leave, and retirement from practice.

The eight physicians interviewed in addition to 38 of the original sample included three new family physicians reported by patients, and five others who had had some contact with patients. All but one, an internist, were general practitioners, and all were in Maryland.

#### The Results

**N**O PHYSICIAN REFUSED the first request for an appointment, and all were generously cooperative with their time and information.

The major report on the family physician's role in relation to these psychiatric patients is pending. Preliminary reports have indicated that the patients had had only limited exposure to the phenothiazine medications (2) and that their major out-patient medical resource had been the physician in general practice (3). This present report is limited to the area of physician-hospital relations.

The isolation of the hospital from the general practitioner was suggested during the study's first phase by the nature of the unsolicited comments recorded—almost uniformly negative. Many doctors implied that hospitalization in Spring Grove was a "last resort," considered by some to be a form of punishment for antisocial behavior. Only two mentioned having made requests to the hospital for reports on their patients.

Of the 46 interviewed during the second phase of the study (regarding 51 patients), only five had had any direct contact with the hospital about their patients. In two cases, the two who had requested reports, the physicians themselves had

initiated the contact. In the other three, the hospital had played the active part, twice by sending referral notes to the physicians via patients on convalescent leave, and once by a telephone call from the out-patient clinic to a physician from whom the patient claimed she was getting medication.

One physician said he knew that his patient had a referral note for him but that she had not been in to see him in the three months she had been on leave.

Two others were to some degree connected with their patients' hospital treatment: one had visited his patient regularly during a previous admission shortly before the one under study; the other received regular reports on his patient from the patient's mother.

To the great majority, their patients' treatment and response in Spring Grove were, as one of them expressed it, "a dead page" in their records.

In answer to the second question, 28 replied that they had never visited Spring Grove; six had visited more than five years ago; five had visited as medical students. Only six had visited the hospital within the past five years in connection with patients under their care, and a seventh visited regularly in a consultant capacity.

Only 44 physicians were asked the third question, to which eight offered no answer. Four thought the current situation satisfactory, requiring no revision. One put the burden of hospital-physician liaison on the patient who, upon release, "should discuss the need for follow-up treatment at the hospital and should then get in touch with me if need be."

Among the 31 who offered suggestions, 21 requested reports on patients leaving the hospital: date of discharge, treatment while in the hospital, recommended follow-up treatment, and prognosis. One of these thought such reports should go to the local public health officer as well as to the private physician originally responsible for the hospitalization. Another asked for the information in advance of the patient's return home so that he might "be ready to continue recommended treatment without delay." A third expressed the opinion that, "some patients are readmitted to the hospital unnecessarily because at the point of their acute disturbance, the family physician has no information about treatment in the hospital to guide him."

There were nine requests for reports other than convalescent leave or discharge summaries: a report when the diagnosis is established and progress reports monthly or semiannually. One considered a monthly progress report only "courteous and wise." Another remarked that when the patient's family calls him for information, he needs to be better informed himself in order to reassure them.

Five considered that the state psychiatric hospital should take responsibility for training physicians in general practice. Institutes, seminars, study groups, symposia, and occasional lectures were suggested by four. Two felt a need for orientation to the new psychiatric medications, one requesting "a reference book on the new drugs." He continued, "Most of our information comes directly from the drug houses. What do hospital psychiatrists feel about each drug? Which do they recommend for the out-patient setting in terms of safety and effectiveness? What drug do they recommend for what symptoms?"

Two physicians suggested consultation by Spring Grove physicians with community physicians treating former patients. One specified "more extreme cases"; the other would like, "Periodic evaluations on an out-patient basis of patients for whom I need reassurance that I'm not missing any major psychotic problems such as suicidal impulses and sexual perversion, and that my treatment is in the right direction."

Many complaints cited the psychiatric hospital's failure to acknowledge the role of the general practitioner, who "Takes over the dominant load of its patients." One termed the rapport between hospital and physician "stinking"; another complained that psychiatrists generally, both in the hospital and in private practice, failed to refer patients back to the general practitioner and to support his relationship with them.

Many commented also on the high proportion of psychiatric disorders in their practices. Said one, "If I were to refer to psychiatrists all my patients who need psychiatry, I wouldn't have any practice left."

Single suggestions included:

The offer by Spring Grove personnel of programs for local medical societies and chapters of the Academy of General Practice.

Simplification of the admissions procedure.



Table I

| Resource to which<br>Spring Grove had<br>referred | Total | None | SGOPD | Psych.<br>clinic | Private<br>psych. | Fam.<br>phys. |
|---|-------|------|-------|------------------|-------------------|---------------|
| Total   | 39    | 11   | 6     | 2                | 5                 | 15            |
| None  | 12    | 6    |       |                  |                   | 6             |
| Spring Grove OPD                                  | 8     |      | 6     |                  |                   | 2             |
| Psych. clinic                                     | 8     | 2    |       | 2                |                   | 4             |
| Private prac.<br>psychiatrist                     | 6     |      |       |                  | 5                 | 1             |
| Family physician                                  | 5     | 3    |       |                  |                   | 2             |

Comparison between resources to which Spring Grove had referred 39 patients with family physicians for out-patient follow-up treatment with resources to which patients had applied.

More care in releasing patients: "Require follow-up visits to a clinic or physician. If the patient fails to make them, pick him up and return him to the hospital."

Education against the element of "stigma" in hospitalization for mental disorder, "not by exposé, but in some clean way."

Assignment of full responsibility for posthospital treatment to the family physician in the case of every patient who has one.

#### SUPPLEMENTARY DATA

Of the 45 patients whose 41 family physicians were interviewed in the follow-up study, five had been in the hospital continuously during the preceding year, and one had eloped from the hospital, his whereabouts unknown. The remaining 39 had been out of the hospital for periods ranging from one to twelve months, for a mean of 8.2 months and a median of nine months. Twenty-three had seen their family physicians since their return home; for 15 of them the family physician was the principal resource for whatever out-patient psychiatric treatment they needed. Only five of the 39 had been referred back to their family physicians by their hospital physicians, however, according to their hospital records.

Table I depicts for these 39 patients the treatment resources to which they had been referred

by the hospital and the treatment resources to which they applied for follow-up care.

#### Discussion

IT WOULD SEEM, from the results of this study, that the cooperation between Spring Grove and community physicians in general practice is negligible and that both sides contribute to the failure of communication between them: the physician by neither visiting the hospital nor requesting reports on his patients; the hospital by neither sending reports to the physician nor referring his patients back to him upon their separation from the hospital.

Closer collaboration between the hospital and the physicians might result in benefits to the patients which would eventually represent a practical economy in terms of reduced periods of hospitalization for the patients concerned. Obviously, further research is needed to test this hypothesis, but it appears to be worth testing. The data indicate that physicians in general practice are actually providing a service for which psychiatric clinics are currently in demand all over the country; namely, outpatient treatment of men and women suffering from mental disorders. If the state psychiatric hospital, by closer relations and more direct communication with such physicians, acknowledges their service,

shares responsibility with them for their patients coming to the hospital, collaborates with them in the management of more difficult patients in the community, is it not possible that this service—already available—can be refined and expanded? Furthermore, would not such a plan

be more practical and less expensive than developing new clinics staffed with personnel in such short supply as psychiatrists, psychologists, and psychiatric social workers?

**Spring Grove State Hospital  
Baltimore 28, Maryland**

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1. Hollingshead, A. B.: Two-Factor Index of Social Position, New Haven, Conn., Dept. of Sociology of Yale University (undated) (mimeographed).
2. Kurland, A. A., et al.: *Am. J. Psychiat.* **115**:28, 1959.
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### PEDIATRIC SEMINAR

The Tenth Annual Pediatric Seminar, sponsored by the Pediatric Department and the Postgraduate Committee of the University of Maryland School of Medicine, will be held Sunday, April 9, 1961, in Gordon Wilson Hall, University Hospital. The following guest speakers will appear on the program:

**John W. Hope, M.D.**, Professor of Clinical Radiology, University of Pennsylvania School of Medicine; Director, Department of Radiology, The Children's Hospital of Philadelphia.

Topic: Abdominal Neoplasms in Infants and Children

**Mitchell I. Rubin, M.D.**, Professor and Head of the Department of Pediatrics, The University of Buffalo, School of Medicine.

Topic: Basis For Fluid Therapy in the Post-Surgical State in Children

**Albert B. Sabin, M.D.**, Distinguished Service Professor of Research Pediatrics, University of Cincinnati College of Medicine.

Topic: Immunization with Oral, Live Polio Vaccine—Recent Results and Recommendations for the Future

**Wolf W. Zuelzer, M.D.**, Director of Laboratories, Children's Hospital of Michigan; Director, Child Research Center of Michigan; Professor of Pediatric Research, Wayne State University, College of Medicine.

Topic: Icterus in Early Life

An intensive psychotherapeutic inpatient program for psychiatric disorders of the aged was introduced at the Chestnut Lodge hospital in December 1958. The program was oriented toward diagnostic evaluation and active treatment, with the goal of discharge. The basic premise was that certain disorders of the aged are recognizable and amenable to treatment. Details of the treatment philosophy as well as plans for its implementation and their rationale, are described with consideration to administration of the program, staffing, admission policies and procedures, diagnostic assessment, the tentative therapeutic program, and accompanying research investigations. The number of personnel necessary to manage a 12-bed unit, furnished and equipped to meet the needs of the aged, was uncertain; but it was considered necessary (1) to place the program in the charge of a clinical administrator (psychiatrist), whose duties would permit 25 hours per week to the program; (2) to have a nursing personnel-patient ratio of 1.5; and (3) to provide one program-oriented internist, a halftime social worker, and a halftime activities therapist. This program may be viewed as a gross statement of the conditions of an experimental undertaking: the testing of the range and limits of the applicability of psychotherapy to the aged.

## **PLANNING AN INTENSIVE**

## **PSYCHOTHERAPEUTIC**

## **INPATIENT PROGRAM**

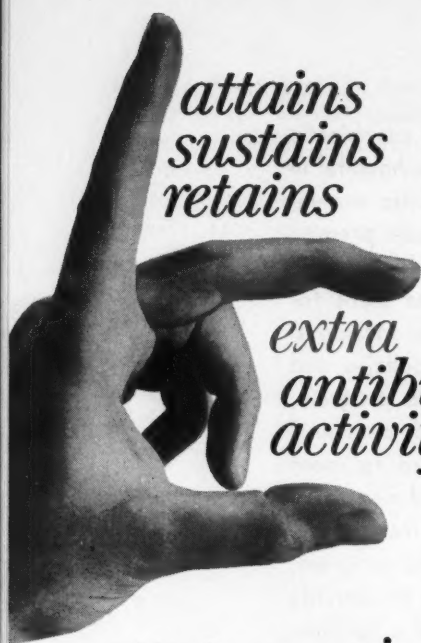
## **FOR THE AGED**

**Robert N. Butler, M.D.\***

**C**OMPARATIVELY LITTLE information pertaining to active psychotherapeutic inpatient programs for the psychiatrically disordered aged is to be found in the literature. It was therefore decided to report the initial planning involved in such a program which was initiated here in December 1958.

This report contains an exposition of the basic orientation (purposes and goals) adopted for this program and an outline of various plans to implement the basic orientation. It considers the administration of the program, staffing, admission policies and procedures, diagnostic assessment, the tentative therapeutic program, and concomitant research investigations. The first nine months' experience with this program and certain observations about the aged and about the psychotherapy of the aged will be reported in a separate communication.

\*Research psychiatrist, Section on Psychiatry, Laboratory of Clinical Science, National Institute of Mental Health, National Institutes of Health, Public Health Service, United States Department of Health, Education and Welfare; formerly clinical administrator, intensive psychotherapeutic inpatient program for the psychiatric disorders of the aged, Chestnut Lodge, Inc., Rockville, Md.



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sustains  
retains*

*extra  
antibiotic  
activity*

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levels promptly*

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**DECLOMYCIN** Demethylchlortetracycline sustains activity levels through the entire therapeutic course, the high activity levels needed to control the primary infection. At the same time, it checks secondary infection at the original site. This combined action is usually maintained without the pronounced hour-to-hour, dose-to-dose, peak-and-valley fluctuations which characterize other tetracyclines.

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**CAPSULES**, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

**PEDIATRIC DROPS**, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

**SYRUP**, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

**PRECAUTIONS**—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy; patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

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| DAYS OF TETRACYCLINE B DOSAGE |   |   |   |   |   |
| DURATION OF PROTECTION        |   |   |   |   |   |
| DAYS OF TETRACYCLINE C DOSAGE |   |   |   |   |   |
| DURATION OF PROTECTION        |   |   |   |   |   |
| DAYS OF DECLOMYCIN DOSAGE     |   |   |   |   |   |
| DURATION OF PROTECTION        |   |   |   |   |   |
| PROTECTION AGAINST RECURRENCE |   |   |   |   |   |

## Basic Orientation

WITH RESPECT to both research and treatment, the aged and the psychiatric disorders of the aged have received insufficient attention in this country, despite the fact that the number of aged and the incidence of psychiatric disorders among them have continued to increase dramatically (1). Insofar as psychiatric investigation is concerned, recent work has demonstrated the amenability of certain groups of the psychiatrically disordered aged to active treatment, including psychotherapy (2, 3, 4, 5). Diagnostic techniques to simplify the recognition of treatable groups among the aged have been refined (6, 7, 8). Thus, the basic premise that certain disorders of the aged are both recognizable and treatable was assumed in undertaking the program here.

Despite recent developments in the field, few diagnostic and active psychotherapeutic centers exist for geriatric patients in this country (9, 10). By and large, the psychiatric disabilities of the aged continue to be regarded as explainable in organic terms and as untreatable; and these patients are relegated to custodial care (11). Furthermore, to our knowledge, no intensive psychotherapeutic units for aged patients are in existence. (Intensive psychotherapy is here defined as individual, insight-oriented psychotherapy involving up to four or five sessions per week with patients in residence in a psychotherapeut-

ically-oriented milieu). Consequently, the inauguration of an active intensive psychotherapeutic program for the aged was considered a novel undertaking in keeping with this hospital's tradition of innovation, which began with its psychotherapeutic program in schizophrenia (12). It also marked the beginning of a transformation from an already existent medical-nursing custodial program here. It was held likely that a successful geriatric program would come to serve as a model for other hospitals and for the community. Moreover, it was felt that such a program would help meet an unfulfilled need in the immediate community, which, like most communities, is devoid of facilities both for the acutely disturbed aged and for the active treatment of the psychiatrically disabled aged.<sup>2</sup>

It was appropriate, indeed necessary, to begin such a program modestly and cautiously; but it was also believed essential that the program be regarded from its outset as oriented toward *active treatment and discharge* and as potentially commensurate in importance to the nongeriatric program. The essential purpose and final goal of the unit was to undertake the diagnostic evaluation and active treatment of elderly patients suffering from a variety of psychiatric disorders, rather than to continue a medical-nursing custodial care program.

Beyond the considerable planning and imagination always required in building a new program, was recognized an additional factor in attempting to develop a constructive geriatric program. An atmosphere of despair hovers over work with the aged; yet notions of "second childhood," "irreversibility," "organicity," and the like are no more desirable nor necessarily applicable in work with the aged than with the chronic schizophrenic patient. In both type patients ample confirmation exists that a more hopeful view is not merely a matter of faith (5, 13).

Further, it was conjectured that an *ideal*, intensive psychotherapeutic geriatric program would be likely to prove more expensive than the existent nongeriatric program, partly because the medical needs of the aged are greater than those of the younger patients. To provide active psychiatric treatment for geriatric patients, over and above the best custodial care, attention was also directed to the financial basis of the program. Since the economics of active treatment programs

<sup>1</sup> Acknowledgments: In addition to the basic and necessary support to this program which the following provided, they also contributed to the development of the treatment philosophy: Marvin L. Adland, M.D., clinical director; Otto A. Will, Jr., M.D., director of psychotherapy; and Dexter M. Bullard, M.D., medical director, all of Chestnut Lodge, Inc. In addition, Donald L. Burnham, M.D., George Sharpe, M.D., Doris Lynch, P.S.W., Elizabeth Mohler, R.N., and Rita Miller, R.N., among others, contributed to both the philosophy and the implementation of the program.

<sup>2</sup> There is also some shortage of custodial residential units. In the immediate county are approximately 1000 nursing and old age home beds, serving a population estimated to be 330,000, living under a wide variety of socioeconomic conditions. The usual cause of discharge is death after one to three years; if psychiatric disturbances intervene, one or more of the following apparently occur: restraint and seclusion (although illegal); transfer to the state hospital which has no active psychotherapeutic program; or utilization of tranquilizing drugs, the use of which has reduced the frequency of the first two alternatives.

for the aged is a national problem, it was hoped that experience here could be contributory to planning such programs.

It was also decided from the outset that evaluation of the results of the program should go hand in hand with the program itself. Satisfactory studies of the therapy of the aged are wanting. Moreover, contributions to personality (e.g. psychoanalytic) theory were expected as important byproducts of work with the aged. The final psychological development of man has been largely ignored by contemporary personality theory. It was anticipated that other age groups and work with other disorders would benefit from the increased understanding of the aged. The study of those who have reached the final period of life, in terms of survival and the character of the survivors, should enlarge our everyday concepts of stress and defense. The meanings of death, of time, of self-perceived changes in body image and physiology, of losses and of grief, of loneliness and of isolation, are among the "themes" about which the aged are particularly experienced, but which are also relevant to the experience of younger patients.

Finally, it seemed imperative that the basic orientation of the geriatric unit be such that the hospital not evolve into two separate hospitals, but rather that the geriatric and nongeriatric programs eventually grow together and become integrated, not only administratively, but by utilization of the same staff and preexistent modes of communication.

### Implementation

ADMINISTRATIVE AND STAFF discussions resulted in agreement with the basic orientation, whereupon an organized program for the diagnostic evaluation and intensive psychotherapy of aged patients with a variety of disorders was instituted in December of 1958. A 12-bed unit was remodeled, furnished, and equipped to meet the particular needs (e.g. physical limitations) of aged patients; however, such segregation would not be forced.

On an individual basis, certain aged patients would be admitted to another service; and, when indicated, middle-aged patients would be admitted to this unit. Only two reasons were considered to justify segregation at all. (The unitary treatment philosophy proposed, of course, refers pri-

marily to the application of psychotherapy and does not preclude group or individual differentiation.) First, because of the particular characteristics, special needs, and physical limitations of the aged, separate residence and a trained staff are useful; second, observations toward increasing our knowledge of the aged would be facilitated by separate residence and by staffing with personnel, trained and experienced in work with the aged.

#### 1. ADMINISTRATION OF PROGRAM

The unit was placed under the direction of a clinical administrator, whose status and duties were made similar to that of the clinical administrators of the other services of the hospital. Cumulative experience has demonstrated here the advisability of dividing the responsibility of the treatment program between the department of clinical administration and the department of psychotherapy. Consequently, each patient has two physicians: his individual physician with whom he is engaged in psychotherapy, freed of complicating administrative decisions, and his administrative physician. The latter is responsible for the general care of the patients of his unit or service, for the maintenance of liaison with the patient's family, and for decisions pertinent to patient management, including the restriction and extension of privileges. The clinical administrator does not carry his administrative patients in therapy, but does carry two patients from other services; thus the clinical administrator has approximately 25 hours weekly to devote to the administration of his service (12 patients in this instance). Although the responsibilities of the administrator of this unit were provisionally defined in terms of the experience of other services, the likelihood was considered that further and differing responsibilities might evolve in this service.

#### 2. STAFFING

Similarly the question of staffing needs was left open, and relevant decisions were expected to evolve from experience; it was difficult to predict the psychiatric needs of a 12-bed geriatric unit. To illustrate: it was initially projected that the nursing staff would be geared to providing four hours per day per patient of nursing time

in the geriatric unit, which figure was greater than the 3.4 hours recommended by the County Supervisor of Nursing Homes. However, it was realized that the appropriateness of this figure would depend upon many factors, such as the effectiveness of the Activities Department, the nature of admitted patients, and the like. The unit was staffed with nursing personnel trained and experienced both in work with the aged and in psychotherapeutic principles. The nursing personnel-patient ratio of 1.5 in this hospital was maintained. (This may be compared to the average state hospital where there is one personnel member to every 10-20 patients). Student nurses on affiliation from nursing schools were also rotated through the service.

Other positions established in the unit were a medical consultant to the program, a halftime activities therapist, and a halftime psychiatric social worker.

Emphasis was placed on having the medical consultant oriented to the program rather than assuming the role of a consultant for particular patients and acute problems. Thus, the consultant was available for collaborative work (e.g. nutritional programming), for maintaining continual contact with the patients (e.g. rounds), as well as for carrying out the initial medical assessment and responding to the usual medical needs of the patients.

### 3. ADMISSION POLICY AND PROCEDURES

Because it was believed that a population of aged patients could stabilize rapidly and put an end to the ideal of an active treatment unit, the initial decision was to undertake careful pre-admission selection and to recommend transfer elsewhere, when indicated, after evaluation and maximal treatment. The following criteria was drafted for admission of patients:

- a. Sixty years of age and over (no upper limit).
- b. Male and female.
- c. Duration of present psychiatric disorder (precipitating admission) less than five years.

<sup>3</sup> It is noteworthy that affective disorders are the most commonly diagnosed disorders of the aged in England, whereas arteriosclerotic and senile dementia are most common in this country (14). This difference raises serious questions relating to methods of diagnosis, cultural differences, and diagnostic bias.

<sup>4</sup> Since the general hospitals ordinarily do not provide treatment for the psychiatrically-disturbed aged, they

d. Diagnostic evaluation indicating the presence of a primarily predominantly psychological disorder. Depressions of neurotic and psychotic proportions, other affective states, and paranoid reactions were expected to make up the bulk of disorders.<sup>3</sup> The concurrent presence of "senile" or "arteriosclerotic" changes or psychosis would not automatically rule out patients, since it is known that affective disorders may simulate organic disorders (15), that the limits of applicability of psychotherapeutic intervention to organic brain disorders of the aged have not been tested, and that the relationship between clinical presentation and postmortem neuropathological changes is controversial (16, 17, 18).

- e. Absence of medically-induced disorders such as mental confusion in the course of cardiac failure, uremia, and the like. (Certain of such patients might require psychotherapy as well as medical treatment and would therefore be accepted).
- f. Absence of severe physical limitations, since an extensive physical rehabilitation program is not planned.

Although it was understood that these criteria would not necessarily define psychotherapeutic accessibility, they represented an appropriate first approximation.

In view of the absence of a diagnostic and active treatment center in the area, few inquiries for admission were expected.<sup>4</sup> Rather, the thought was that families and physicians would refer the disturbed aged for diagnostic evaluation and treatment; nursing and old-age homes would refer patients who developed disturbances in the course of their stay for the treatment of their immediate disturbance, to be returned to the home if further treatment could not be recommended; and physicians, management consultants, and the like would refer patients suffering from depressive disorders apparently related to retirement crises, death of spouse, and similar circumstances.<sup>5</sup>

To further avoid the possibility of unwittingly are usually referred to nursing or old age homes. Although psychiatric treatment might be indicated, there are no legal requirements for psychiatric evaluation to determine treatability.

<sup>5</sup> The increased incidence of depressive reactions in the aged probably reflects the increased incidence of such crises and losses so prevalent in the period of old



achieving an inactive "backward" geriatric population, both the families and patients would be informed that a time-limited evaluation would be undertaken (e.g. 60-90 days), at the end of which period the family would be apprised of the patient's condition. The following general categories of recommendations were tentatively proposed:

- (1) Good prognosis; apparent amenability to psychotherapy. Further hospitalization and therapy advised.
- (2) Return home improved or recovered; treatment to continue in the community or as a hospital outpatient.
- (3) Prognosis poor. Custodial care indicated, and referral to a different facility made with recommendations for management provided.

#### 4. DIAGNOSTIC ASSESSMENT

Prevalent "diagnostics" in the aged emphasize cognitive (i.e. organic) assessment, but psychodynamic evaluation (with particular stress upon current life-experiences such as losses) was considered indicated. Psychological testing would include recent refinements which aid in recognizing the depressed, for example, whose preoccupation, apathy, and consequent poor test scores lead to the faulty diagnosis of "organic brain disease." The Wechsler-Adult Intelligence Scale, Rorschach, and Wechsler Memory Test would be routinely administered. Observations would be made on the unit to evaluate the responses of the oldster to his perceptual defects, diet, etc., which are so important in the aged. An extensive medical evaluation would include an electrocardiogram and specific tests of audition and vision. Since adequate nutrition presupposes adequate dentition in the aged, dental evaluation would be scheduled. Neurological study would include electroencephalography and skull x-rays. Family evaluation would be conducted by the psychiatric social worker (and the clinical ad-

age. It is surprising how few such reactions appear to be treated early. Only 1 per cent of American psychiatrists spend full time in geriatric practice, while 40 per cent treat no patients over 65 (19). Undoubtedly a number of such patients improve or recover under the care of their medical physician (or fend for themselves), but probably a sizeable percentage become chronic and worse, eventually being admitted to homes or to state hospitals (by which time the diagnosis of organic brain disorder is applied).

ministrator would supplement or collaborate when indicated). Such overall (extensive and intensive) evaluation would take into account the multiple factors considered relevant to the overall condition of the aged patient. Psychiatric evaluation would be especially directed toward predicting therapeutic accessibility and prognosis (e.g. estimating length of treatment required, nature of outcome expected, and factors favorable and unfavorable with respect to a good therapeutic result).

#### 5. PROVISIONAL THERAPEUTIC PROGRAM

The essential purpose of this hospital, and its impetus, is the psychotherapeutic process in which the significance of human relationship and of insight is emphasized. Goals include the betterment of the patient in terms of improved performance, gain in satisfactions, increased personal security, some measure of insight, as well as decreased symptomatology.

As previously stated, the treatment philosophy of this program was that the aged patient be regarded and treated in the same way as patients of other ages and in various diagnostic categories. With this basic standard accepted, it was understood that modifications would be introduced as indicated by the nature of the aged and the character of their disorders.

As initially planned, patients would be assigned therapists of the hospital staff following evaluation.

Weekly patient-staff meetings conducted by the clinical administrator would be held. These meetings would be conceived initially as a social function and a method of assessment rather than structured as group therapy.

The Activities Department would play both an indirect and a direct role. It would participate in the instruction of nursing personnel to bring them up to date with recent advances in the field of activities, and it would work directly with the aged. As noted earlier, the segregation of the aged into a separate unit would apply only to residence. The patients would be encouraged to participate in the various hospital activities, including recreation, manual arts, voluntary and paid work programs, outings and picnics, and patient committees. Hobbies and activities were not to be "forced" upon patients, but the opportunities would be presented and individual atten-

tion and interests encouraged. Stimulation without insistence was held important. Isolation and the loss of social and other skills are frequent consequences of ordinary custodial programs.

The clinical administrator and program internist would collaborate; i.e., in nutritional problems, since the dietary habits of the aged appear often to have both a "personal" or psychodynamic meaning as well as a medical aspect (e.g. anorexic effect of certain drugs).

The clinical administrator and the psychiatric social worker would provide continuous contact with the families, for family attitudes were felt to be more pertinent to favorable outcome in this age group than in others. Older patients frequently are "abandoned" or "unwanted" after hospitalization, a factor influencing outcome.

#### 6. RESEARCH INVESTIGATIONS

At the outset, evaluation of the program was

planned to proceed contemporaneously with the program itself. Objectives included study of the psychotherapeutic process itself and its possible modifications in the aged, as well as evaluation of the results of an active psychotherapeutic program for aged patients hospitalized with predominantly functional psychiatric disorders. Full-scale investigations are under consideration for the near future; the testing of procedures for evaluation (e.g. ward behavior scales) were initiated at the beginning. It was believed that such investigations relating to the psychotherapeutic process in the aged, to the acquisition of data pertinent to the psychology of the aged, and to the prognostic aspects of disorders of the aged would be of considerable significance both to public health and to mental health research.

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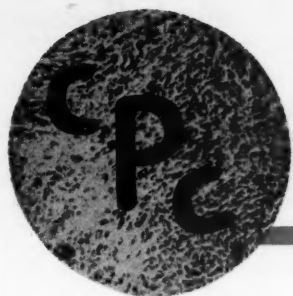
### PHI DELTA EPSILON FRATERNITY

Delta Epsilon Chapter and Baltimore Graduate Club announces its  
Annual Lectureship

Subject: *Medical Problems of Man in Space Flight*

By: Lt. Col. Charles A. Berry, USAF, M.C., Aerospace Medicine Division

At the University of Maryland School of Medicine at 8:15 P.M., Wednesday, April 19,  
1961. Auditorium of the Medical School Library, Lombard and Greene Sts., Baltimore  
1, Maryland.



• *clinical pathological conference from Union Memorial Hospital, Baltimore, Maryland.*

Walter C. Merkel, M.D.

RTS, autopsy number A2157. The subject was a 64-year-old white male clerk. History was difficult to obtain. According to the family physician, the patient had attended an informal dinner party, at which time he supposedly consumed, by his own statement, "The biggest and best meal" he ever had, including oysters on the halfshell, cocktails, and a full course dinner, which took place in the early evening. On arriving home, he was seized with nausea, vomiting, and an "indescribable excruciating pain" which did not subside. He was admitted to the hospital at 2:20 A.M., the morning after the party, with extreme chest and upper abdominal pain.

*Family history* was noncontributory. He was in general good health, having had no serious illnesses or operations. He remained in good health until 10:30 P.M., when he became nauseated and vomited. He felt relieved for a short time, then had severe crampy pains in the right upper quadrant and over the precordium. At times the pain migrated to the left shoulder and was agonizing. His color became poor, and the patient was sent to the Accident Room by his family physician. At 2:35 A.M. the patient was given 11 mgm. of morphine and 4 mgm. of atropine. He had received 26 mgm. of morphine at 11 P.M. the night before, with no result.

*Physical Examination:* Blood pressure 180/100. The patient was a small, thin, 64-year-old male in pain, gasping for breath, and in marked acute distress. Lips, fingers, and nail beds were cyanotic. Pupils reacted to light and accommodation. Neck was supple without venous distention; trachea in midline. Lungs were clear to P. and A. The heart was not enlarged, rhythm regular, rate rapid, sounds of fair quality, no murmurs. Abdomen was rigid with some tenderness in the epi-

gastrium. Slight tenderness was felt over the cardiac area. Extremities were unimportant.

*EKG* showed sinus tachycardia, normal conduction time, and no evidence of myocardial damage.

*X-ray, single view of abdomen, diaphragm not included:* In general, there was no abnormality nor gross evidence of any opaque urinary or biliary tract calculi; nothing to indicate intestinal obstruction.

*Lab Studies:* Emergency WBC 22,000 (following morning after intravenous therapy and operation). Urine, no RBC, occasional WBC, albumin and sugar negative. Hemoglobin 15 grams or 103 per cent. Sedation rate 6, hematocrit 49. After transfusion and glucose, sugar was 178. N.P.N. 35.7.

At 4 A.M. the patient was taken to the operating room and explored. At operation there was no free fluid, no evidence of ulcer, and though the liver was slightly enlarged, it was a good color with a smooth surface. The gall bladder was small and emptied easily. Pancreas normal, Appendix palpated but not indurated. Operation was done with a right paramedian incision.

*Postoperative diagnosis:* no disease of the abdomen. Patient left the operating room at 6 A.M. and died at 9:50 P.M. Nothing was unusual about the postoperative course. Temperature on admission was 100, at death, 104. Respirations rose to 48 per minute.

### Diagnosis

Before stating the autopsy findings, I would like to add that pain should have been underscored, because it was so excruciating that 26 mgms. of morphine offered no relief. In *Surgery*,

## Autopsy Findings

Perforation of the esophagus just above the junction with the cardiac end of the stomach, a one and one-half inch slit from which fluid, food particles, and blood escaped into the left pleural cavity; a fibrinous pleuritis, left; and compression of the lower lobe of the left lung. There is no evidence of any diaphragmatic hernia nor any evidence of ulceration.

## Discussion

Most esophageal ruptures are presumably caused by vomiting with a full stomach. The musculature is latticed in such a manner that the lower end of the esophagus is not actually controlled by a valve. During the vomiting, the bulging brought about by the food within the stomach may separate the figure eight type of muscle arrangement to such an extent that the supporting fascia will tear, producing a rent. It is not unusual to find no hemorrhage or very little hemorrhage with these types of perforations.

Cases of this type may have to be diagnosed by experience, speculation, and chest x-rays. There is very little from the standpoint of diagnostic aids, otherwise shock is undoubtedly the outstanding complication.

Union Memorial Hospital  
Baltimore 18, Maryland

The American Physicians Art Association of the American Medical Association is planning a "best yet" art show again this year during the American Medical Association convention in New York City. An adequate and choice exhibit space has been allotted in the magnificent exhibit building, where more than 20,000 doctors, their families, and friends are expected. All members of the AMA are urged to join the A.P.A.A. and send their art pieces, including oil and water color paintings, sketches, sculpture, and photography. For further information, please write the A.P.A.A. secretary in New York City, Albert A. Richman, M.D., 307 Second Avenue, New York 3, N. Y.

## Book Reviews

**The Kybernetics of Natural Systems**, D.&K. Stanley-Jones, New York, Pergamon Press, 1960.

Starting with only a few simple definitions of negative and positive feed-back, stability, oscillation, runaway, the author tries to find an answer to questions of present-day physiology and medicine. Whether he succeeds or not remains to be seen.

**Modern Occupational Medicine**, A. J. Fleming, M.D., and C. A. D'Alonzo, M.D., Philadelphia, Lea and Febiger, 1960.

With contributions from 22 medical and health authorities in the duPont Corporation, this book provides essential information on how to organize a medical service in industry, on the influence of physical and chemical environments on health, and on the control of occupational hazards. It is an excellent text and one which people interested in this field should have easy access to.

**The Management of Fractures and Soft Tissue Injuries**, (ed. 7) Committee on Trauma of the American College of Surgeons, Philadelphia, W. B. Saunders Company, 1960.

The entire work, which is divided into three parts, has been revised into a cohesive account of the two principal areas of the modern treatment of trauma. With an index to the whole, this book provides a handy reference source.

**Fundamentals of Chest Roentgenology**, Benjamin Felson, M.D., Philadelphia, W. B. Saunders Company, 1960.

Intended as an unobtrusive consultant to the busy physician, this book, while not complete in its subject area, is comprehensive enough for reference purposes.

**Outline of Pathology**, John H. Manhold, Jr., M.D., and Theodore E. Bolden, D.D.S., Philadelphia, W. B. Saunders Company, 1960.

Part I consists of a relatively thorough treatment of basic pathologic processes. Part II contains the specific characteristics and variants of the basic processes as they apply to the organ systems. No startlingly new material is offered here. A middle of the road viewpoint has been taken on controversial issues.

**Clinical Obstetrics and Gynecology**, Paul B. Hoeber, Inc., September, 1960.

This newest issue of the quarterly publication boasts a list of distinguished contributors. Its contents includes a symposium on Bleeding and Hemorrhage in Late Pregnancy, special articles dealing with frigidity, and historical essays.



## COMMITTEE FOR THE STUDY OF PELVIC CANCER

(Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society)

Howard W. Jones, Jr., M.D.  
Chairman

*The Committee for the Study of Pelvic Cancer presented cases for discussion at the Obstetrical and Gynecological Conference at the University Hospital on Monday, December 19, 1960. On January 9, a meeting was held at the Franklin Square Hospital in conjunction with the regular quarterly meeting of the general staff of the hospital.*

### Abstracts of case discussions:

A 51-year-old patient, married, gravida 4-0-4-3. The patient's menses ceased in 1958, and she had no bleeding for approximately one year. In December of 1959 she had profuse vaginal bleeding for two days, which she thought was a menstrual period, a "part of the menopause," and did not consult a doctor. She had no further profuse bleeding but occasionally noted some slight bleeding after a douche. In late August 1960, she developed low back pain and lower abdominal pain, which became quite severe. Because of this pain and the onset of urinary symptoms, she consulted a physician on September 25. The doctor made a pelvic examination and told the patient that he could not find anything wrong in the pelvis and that her pain probably was caused by gall stones. Some oral medication was prescribed. The patient returned to this physician several times. In early November, at the time of very severe pain, she was taken to a second physician. She was admitted to the hospital on November 10 for a dilatation, curettage, and biopsy of the cervix, with the diagnosis of carcinoma of the cervix. She remained in this hospital until she was transferred to a second hospital on November 25 for treatment.

*Diagnosis: Carcinoma of the cervix, international classification, stage III.*

*Treatment: Radium and cobalt therapy.*

CHAIRMAN: We have some further information from the second physician in which he describes the cervix as very irregular and hard, with induration into the left parametrial region. This was from his examination at the time he first saw the patient.

This patient had no bleeding for approximately one year, which is the usual standard for considering a patient postmenopausal. She then had profuse bleeding for two days but did not consult a physician because she considered this a menstrual period. She did not have further profuse bleeding but did have bleeding after douching. She did not consult a physician until late September, or about ten months after the first episode of bleeding. This appears to be patient delay no matter how you look at it.

How do you feel as far as the physicians are concerned in this case?

PHYSICIAN: I would like to know if the first physician made a speculum examination or only a bimanual examination?

CHAIRMAN: We have no information from this physician, although we have written to him. According to the information obtained from the patient, a speculum examination was not made.

PHYSICIAN: I think this is important. The patient had a history of bleeding. She was examined, but probably only bimanually, and no further attempt was made to find out where the bleeding was coming from. This is certainly delay.

PHYSICIAN: In my opinion it was more than the wrong approach to the physical complaints. It was actually gross mistreatment or whatever you call it.

CHAIRMAN: We have preferred to limit our discussions to the problem of delay and not treatment. Certainly the diagnosis was missed, although the patient returned to this physician several times.

Do we agree that this case shows both patient and physician delay?

COMMITTEE MEMBER: There is, of course, no delay on the part of the second physician.

PHYSICIAN: I would like to ask one further question. This patient was treated with radium and cobalt therapy. Is this considered definitive treatment, or should the doctors have followed through with a hysterectomy?

CHAIRMAN: In a stage III carcinoma of the cervix, radium application and external radiation is the accepted treatment of choice.

COMMITTEE MEMBER: The purpose of these meetings is educational, not just to decide as to the fact of delay or the responsibility for delay. I would like to know what we can learn from this case.

PHYSICIAN: I think the most important thing to be learned is that any patient with a history of irregular bleeding should have a speculum examination of the cervix and then a Papanicolaou smear. This is a simple thing and should always be done. The first thing to do is a bimanual examination, then a speculum examination, and then a smear. With these procedures, the doctor is alerted to the proper diagnosis and treatment. Of course, I think every woman should have a Papanicolaou smear at least once a year whether or not she has symptoms. In this way, the disease may be picked up in its earliest stage, when it is intraepithelial carcinoma, and before the patient has any symptoms.

PHYSICIAN: The great factor in this case was patient delay, and this is often true. I think more should be done to educate the public. This patient

had been having irregular bleeding for a good many months before she went to the doctor. If anything was going to be done to help this woman, then was the best time to do it.

CHAIRMAN: Certainly the sooner the patient gets to treatment, the better. We keep hammering away at the education of the public, but it is hard to know how much gets through.

PHYSICIAN: In regard to this matter of making a speculum examination and taking a smear, I would like to say that, as a medical man, I do make a speculum examination, but I do not take a cancer smear. If anything in the patient's history or on inspection of the cervix indicates she should have further examination, I send her to a gynecologist and make an appointment for her to see the gynecologist the next day. I feel I would only spend too much time waiting for the results of the smear and that it is better to send the patient on to a gynecologist.

PHYSICIAN: I think you have a point, but there are a good many places in the city where a Papanicolaou smear may be read and reported without any significant delay.

PHYSICIAN: I agree that we need to continue the effort to educate the public to go to a doctor, but the doctors need to be alert to all the aids to early diagnosis. Though patients often delay, we still find intelligent patients who go to a doctor promptly; and then there is delay on the part of the doctor in making the diagnosis.

PHYSICIAN: In the case we were discussing, the delay from the time the patient first saw a doctor until she saw a second doctor and was hospitalized was only a little over a month. The patient delayed about ten months.

PHYSICIAN: Yes, but if the patient had continued to go to the first doctor, the delay might have been indefinite. He did not make the examinations indicated nor send her to a specialist nor to a hospital.

PHYSICIAN: Unless the doctor proceeds in the proper way, it does not make much difference when we get the patient there.

PHYSICIAN: Unquestionably, both doctors and patients must be alerted to the significance of early symptoms. It is often the man in general practice who has the greatest responsibility in this regard because he is the one who first sees the patient.

PHYSICIAN: And ability to pay should not be any deterrent because there are many places a patient can go. If we are going to cure cancer, we *must* get it early.

PHYSICIAN: I would like to make one more point. I am an ophthalmologist, and in this field I think there are pretty well established limits within which a man in general practice may follow a patient with an eye difficulty before referring him to an ophthalmologist. Is there any set standard for a man in general practice to follow in regard to referring a patient to a gynecologist?

COMMITTEE MEMBER: This is a little difficult to answer. He should make a speculum examination and do a smear and then he may be guided by the results. If there is any history of irregular bleeding—intermenstrual bleeding, postcoital bleeding, postdouché bleeding—the patient should be referred to a gynecologist or to a hospital clinic as soon as possible.

*A 30-year-old patient, married, para 4, the youngest child having been born February 27, 1960. The history as given by the patient indicates no menstrual irregularity or abnormal bleeding previous to the last pregnancy. During this pregnancy, she had slight vaginal bleeding a few times. This was first noted at about three months, at which time she consulted her physician. She says that a pelvic examination was made and that she was told no abnormality could be made out. She had two or three other episodes of very slight bleeding, but no further pelvic examination was made. There was no unusual difficulty at delivery. The cervix was inspected after delivery, and the physician reports, "It did not appear abnormal." On April 15, the patient returned for her postpartum checkup, complaining of continuous spotting since delivery. Examination re-*

*vealed a friable cervix, bleeding on contact wherever touched, "obviously malignant." The diagnosis was confirmed by biopsy, the lesion being considered a stage II. She was referred to a second physician, and on April 25, had a radical Wertheim hysterectomy. In late June she was referred to a second hospital for evaluation as to further therapy. On June 29, she had vaginal application of radium and subsequently a complete course of deep x-ray therapy.*

CHAIRMAN: We have a letter from the first physician, the obstetrician, giving some further information. He saw the patient for her first prenatal visit on August 20. He notes her last menstrual period as May 29, but she had slight spotting for one day on June 15. The patient says that she was examined at this time, but the doctor does not make note of any pelvic examination. He followed her monthly, having noted that the patient complained of a small amount of spotting on August 10 and again on December 15; but a pelvic examination was not made. On February 27, she had an uncomplicated delivery, and there was no abnormal bleeding. He reports that the cervix was inspected postdelivery and that it did not appear lacerated or abnormal. When the patient returned for her six-weeks postpartum check, the examination was as noted on the abstract.

The operative note from the surgeon states, "There were nodes along the iliac vessel and obturator vessels on the right." The slides reviewed at the second hospital showed several nodes with tumor present.

PHYSICIAN: Did this patient ever have a Papanicolaou smear?

CHAIRMAN: No, this was not done.

PHYSICIAN: I would think the spotting was indication for at least a smear. This would almost certainly have been positive, and a biopsy would have established the diagnosis.

PHYSICIAN: I assume that an examination was made with a speculum, but do we have definite information about this?

CHAIRMAN: The notes from the doctor do not say. I understand that the patient says that a speculum examination was made.

PHYSICIAN: There is no indication of delay on the part of the patient here, but I think there was delay by the physician. At the least a Papanicolaou smear should have been done. This would almost certainly have indicated the need for a biopsy, and the diagnosis could have been established when the pregnancy was comparatively early.

PHYSICIAN: I think that not only the first physician but also the second physician delayed. The surgery was done promptly after the diagnosis was made, but when the nodes were found to be positive, the surgeon must have realized, or I hope that he realized, that he had not treated the patient adequately, and further therapy should

have been started promptly. There was delay from late April to late June before the patient was referred for further therapy.

CHAIRMAN: Do we know if there were any complications that caused delay in referring the patient?

SECRETARY: There were no complications mentioned in the report from the surgeon.

PHYSICIAN: Was the patient actually referred by the surgeon, or did she make her own decision to seek another opinion?

SECRETARY: It is my understanding that she was referred.

PHYSICIAN: I still think she should have been referred earlier.

## EYE, EAR, NOSE, AND THROAT MEETING

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia on April 6, 7, and 8, 1961.

The guest speakers on ophthalmology are:

Irving H. Leopold, M.D., of Philadelphia, Pennsylvania  
Harvey E. Thorpe, M.D., of Pittsburgh, Pennsylvania

The guest speakers on otorhinolaryngology are:

John J. Shea, M.D., of Memphis, Tennessee  
F. Johnson Putney, M.D., of Philadelphia, Pennsylvania

A non-member registration fee of \$25 covers all the social and scientific sessions, and entitles graduate doctors of medicine to associate membership in the academy. A special convention rate will be available at the Greenbrier.

For further information write to Worthy W. McKinney, M.D., secretary-treasurer, 109 East Main Street, Beckley, West Virginia.



## COMPONENT MEDICAL SOCIETIES



### ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

*Journal Representative*

#### DR. ROTHSTEIN RETURNS FROM HAITI

Martin M. Rothstein, M.D., of Frostburg, treasurer of the Allegany-Garrett County Medical Society, assisted the Medico program in Haiti during the recent holidays. Although the town has 10,000 people riddled with disease and a high incidence of venereal infection, Dr. Rothstein was full of praise for the good manners and high moral standards of the Haitians. Poverty, combined with superstition and lack of education, is the reason for all the sickness.



What makes man human is the sublime tragedy of the limitations imposed on his organism by biology and on his life by time.

—Pasteur

#### DR. LEO LEY HEADS STAFF OF SACRED HEART HOSPITAL

At the annual meeting of the medical staff of the Sacred Heart Hospital, **Leo H. Ley, Jr., M.D.**, was elected president for 1961.

Other officers elected are **J. G. Stegmaier, M.D.**, vice president, and **T. F. Lusby, M.D.**, secretary.

#### BIRTHS

**Dr. and Mrs. Alvin J. Walters**, of Frostburg, announced the birth of a daughter, **Theresa Ann**, on December 22.

#### PERSONALS

**Kathryn Skitarelic**, daughter of **Dr. and Mrs. Benedict Skitarelic**, Cumberland, is editorial writer of her high school newspaper. An editorial written by her was selected as one of the three best to appear in high school papers throughout the United States in 1960. Congratulations!

Participating in a panel discussion on "Changes in Trends in Medicine" at a recent meeting of the Cumberland Civic Club, were **Carlton Brinsfield, M.D.**, acting as moderator, **Leland B. Ransom, M.D.**, and **William P. James, M.D.**

**L. Michael Glick, M.D.**, Cumberland, represented the Allegany-Garrett County Heart Association at the regional postgraduate educational meeting held recently at the Hopkins Club, Baltimore. Among matters discussed was the new technique of closed chest cardiac resuscitation.

## ANNE ARUNDEL COUNTY MEDICAL SOCIETY

SAMUEL BORSSUCK, M.D.

*Journal Representative*

The regular meeting of the Anne Arundel County Medical Society was held at the Officers Club of the Naval Academy, in Annapolis, on January 18, 1961. After cocktails and dinner, representatives of the St. Paul Insurance Company explained the professional liability insurance which has been endorsed by the State Society and answered questions asked by various members.

On May 17, 1961, a joint meeting with the medical officers of the Second Army will be held.

A committee consisting of **John F. Hawkins, M.D.**, **William P. Stephens, M.D.**, and **Edward G. Skerrett, M.D.**, was appointed to meet with representatives of the Anne Arundel Ambulance-Rescue Association to formulate policies of operation in various medical situations, including handling of emergency maternity patients. The Society recognizes the magnificent job done by the ambulance and rescue crews of the County. This committee is to aid them in every way possible in for-

mulating policies and possibly in training the crews if desirable and feasible.

**C. Casillias, M.D.**, was voted into membership in the Society, and **Dr. O'Herlihy** was introduced as a new member.

The following officers were elected for the ensuing year: President, **Randall M. McLaughlin, M.D.**; Vice President, **Frank M. Shipley, M.D.**; Secretary, **William N. Thomas, Jr., M.D.**; Treasurer, **Neil H. Sims, M.D.**; Delegates, **Hubert F. Manuzak, M.D.** (three years), **Manning W. Alden, M.D.** (two years), **Fred Hawkins, Jr., M.D.** (one year); Alternate delegates, **Edward S. Beck, M.D.** (three years), **Robert A. Riley, Jr., M.D.** (two years), **Jesse L. Wilkins, M.D.** (one year); Delegate to Planning Committee, **Merton Waite, M.D.**; Alternate, **Richard N. Peeler, M.D.**; Journal Representative, **Samuel Borssuck, M.D.**; Board of Censors, **Clayton Norton, M.D.** (three years), **Francis Codd, M.D.** (two years), **James R. Martin, M.D.** (one year).

## BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

*Journal Representative*



The first meeting of 1961 was held in Osler Hall, with the new look. The progress of the remodeling impressed everyone on entering the foyer. The roomy cubicle for the charming receptionist with her PBX, the new room for checking hats and coats, and the cushioned red chairs, wonderfully comfortable, made us realize how fundamental are the changes going on. The facing platform combined a temporary, folding-type table with massive, vintage chairs fugitive from the old regime. Truly the

building passeth from pupa to larva in its metamorphosis, yet ash trays still slide from the seats.

President **Charles W. Wainwright, M.D.**, presided, flanked by our new secretary, **John F. Hogan, Jr., M.D.**, and our 'old' treasurer, **Russell S. Fisher, M.D.** Beginning the meeting with the scientific session, President Wainwright introduced **Robert J. Dickson, M.D.**, moderator of the evening's symposium on "Radiation Therapy in Malignant Disease."

He sketched Doctor Dickson's background, from his school years in England to his present position as associate professor of radiology in charge of radiation therapy at the Johns Hopkins Medical School and Hospital.

Doctor Dickson introduced the subject with a short series of brilliant color slides. These were starkly illustrative of bad and good results of lesions treated by radiation therapy "because they were deemed beyond the bounds of reasonable surgery."

The first paper of the symposium was given by **Harry Louis Berman, M.D.**, head, Division of Radiation Therapy and Isotopes, Sinai Hospital, Baltimore. The moderator declared him an unusual phenomenon: an American-born-and-trained radiotherapist with long experience in the Army, at Walter Reed, before coming to Sinai Hospital.

Doctor Berman opened his topic—malignant lesions susceptible to external radiotherapy—by mentioning and briefly sketching the evolution of new machines available to radiotherapists, many of which are still in the research phase of application. These supervoltage machines are wonderful and facile; yet they do not replace clinical knowledge and judgment in their application to patients. Dr. Berman classified lesions known to be both refractory and susceptible to external radiotherapy. He outlined the chief uses of this form of treatment with regard to use for primary therapy or for secondary effects in preparation for or prophylaxis after surgery.

Doctor Dickson then introduced **Carlo A. Cuccia, M.D.**, associate professor of radiology at the University of Maryland. Doctor Cuccia had trained in Italy, where pioneer work in radiation therapy has been done. He came to Maryland after having worked in other centers for radiologic research. Doctor Cuccia's topic was malignant lesions susceptible to internal radiation therapy. He decried the fact that the reputation of radium therapy seemed to be worse than that of x-ray therapy in respect to its complications, reactions, and survival. Admitting that this might be due, in part, to complications blamable to lack of proper dosimetry, Dr. Cuccia held that knowledge of dosimetry and availability of proper measuring devices were elementary require-

ments in getting the best results possible. He defined radium therapy essentially as therapy from any implanted substance emitting gamma rays. Among its advantages over x-ray were the possible accuracy and increased available potency with interstitial placement, so that the skin is not traversed by heavy density radiation. He showed lesions of the oral cavity and the vulva with x-ray pictures showing the grid-placement of 'needles.' The before and after results were dramatic.

Doctor Dickson completed the symposium with a summation of isotopes and chemotherapy. He regretted the fact that hopes for the effectiveness of synthesized isotopes had not been sustained except in the fields of secretory thyroid malignancy and blood dyscrasias, particularly polycythemia. He mentioned, among various isotope methods, radioactive gold bullets implanted with a neat looking gun, binding lesions with radioactive tantalum wire, and pumping colloidal isotopes into body cavities, as some of the avenues tried with varying success. A great advantage of radiotherapy over surgery in malignant disease is that it permits retention of normal contours and functions, especially in the oral cavity. Prejudice in favor of surgery, he derided, sometimes is carried so far as to permit "the triumph of technique and mutilation over good sense and comfort." Prejudice against radiotherapy magnifies any complications that result from it, although the complications are no more than occur after surgery, when they are accepted without comment.

As a final admonition, Dr. Dickson reminded us that no one specializing in one field knows what other methods for treatment of malignancy will accomplish. Patients with extensive lesions should have benefit of consultation regarding other pertinent types of therapy. The opinions of experts in several fields should be obtained and the best hope given the patient. Doctor Dickson concluded with a wry observation that a radiotherapist in England this year made the Queen's Honors List; thus, radiotherapy now rates along with cricket playing and horse racing, whose experts regularly appear on the list.

A brisk business session followed the scientific portion of the meeting. Minutes were read

and approved, and the secretary cast the ballot electing new members.

Amendments regarding membership had been scheduled for discussion at this meeting. After a motion had been debated and carried that these be sent back to committee pending completion of alterations and changes in the Faculty's constitution and bylaws, since the bylaws of component societies must conform to those of the State Society, President Wainwright directed that this be done.

The annual budget was presented by **Russell S. Fisher, M.D.**, treasurer, and accepted without comment.

Under new business, the legality of denying members their votes by mail or by proxy was challenged. The legal philosophy under which nonstock corporations have been chartered by Maryland since colonial times was reviewed, and it was claimed that state law, quite apart from the Faculty's Constitution, gave all members an inherent right to vote in person or by proxy. The proposal that the amendment, defeated at the last meeting, be submitted to legal opinion was passed after discussion.

This action opened the gates for challenge to the Executive Board and officers regarding actions taken at previous meetings about which the challengers seemed poorly informed. Ignoring your representative's plaintive plea that business be reserved for *business* meetings, many points of controversy were belabored and Robert's Rules of Order worked overtime before the motion to adjourn was put through.

Many of us regret that Ellen has not yet found an outlet for her hotplate, so that coffee and doughnuts can be available in our NEW Osler Hall.

\* \* \* \* \*

The Executive Board met on January 10 for the first time in 1961, with **President Wainwright** presiding. A quorum was present, and the business at hand was entered upon with interest and energy. Adding force and drive to the proceedings were five new members: **Vice President Harry M. Robinson, Jr., M.D.**,

**Secretary John F. Hogan, Jr., M.D.**, and elected members **Harry J. Connolly, M.D.**, **D. Frank Kaltreider, M.D.**, and **E. Roderick Shipley, Jr., M.D.**

Secretary Hogan read the minutes of the 1960 Board's last meeting. These were discussed and amplified for the benefit of the new members.

The request from the Faculty's Nominating Committee for names of City Society members who would be approved for nomination as an officer in the State Society was considered. Last year this request was circularized by the Executive Board to the entire City membership. This year only the Executive Board was notified. Policy discussion ranged from the one extreme that to propose ANYONE would make the Board open to charges of factionalism, to the other extreme that the Board should suggest a large number of names to avoid allegations of bias.

The proposed amendment to the Constitution and Bylaws regarding membership, limping in from the last meeting, was discussed again en route to its committee rehearings. The new members of the Board were told of the background of the proposed changes as well as of the requirement that our Constitution conform to that of the State Society.

**Treasurer Russell Fisher, M.D.**, announced that the room assigned to the Baltimore City Medical Society in the remodeled building is ready for occupancy. Furniture and office equipment suitable for the large volume of work done by Mrs. Maguire have been selected, the cost of which was included in the budget passed at the last meeting. The treasurer was instructed to proceed with the necessary purchases.

Dr. Fisher called attention to a number of associate members who are in fact licensed and actively practicing medicine and are, thereby, ineligible for associate status. The Board declared that it was the treasurer's duty to review the roster of associate members and to contact those eligible to fulfill the requirements for election to active membership. To continue associate membership indefinitely was deemed not in the best interests of the Society.



## HARFORD COUNTY MEDICAL SOCIETY

J. RALPH HORKY, M.D.

*Journal Representative*

Elected officers for 1961 are: President, Willard P. Hudson, M.D.; Vice president, Robert Folweiler, M.D.; Secretary, William Tyson, M.D.; Treasurer, George Stansbury, M.D.; Delegates, Phillip Heuman, M.D., Dudley Phillips, M.D.; Alternates, Robert Barthell, M.D., Fred Hatem, M.D.; Planning Committee, J. Ralph Horky, M.D., Richard Norment, M.D.

All minutes and actions of the County Society in 1960 were affirmed, as well as actions taken by the State Society.

All members voted to sustain financially in both the County and State Societies the memberships of Benjamin Dorogie, M.D., and Alex Sandecki, M.D., who have limited their practices because of illness. The membership also approved the collection of AMA dues by the Medical and Chirurgical Faculty.

## FREDERICK COUNTY MEDICAL SOCIETY

L. R. SCHOOLMAN, M.D.

*Journal Representative*

The regular January meeting was held at the Francis Scott Key Hotel on the 17th. John Culler, M.D., the newly elected president, presided. The guest speaker, Mark Ravitch, M.D., associate professor of surgery at Johns Hopkins, served a potpourri of potbellied pediatric exotics which were more astonishing than appetizing.

During the business meeting which followed

Dr. Ravitch's presentation, the members were reminded of the forthcoming clinical program of The Heart Association, sponsored by both the Frederick and Washington County groups, to be held in Hagerstown on January 25. The date of a testimonial dinner to be given by the board of managers of the Frederick Memorial Hospital for Miss Ethel Northam on her retirement as director was announced.



## MONTGOMERY COUNTY MEDICAL SOCIETY

CHARLES FARWELL, M.D.

*Journal Representative*

Maynard I. Cohen, M.D., is sadly missed by all who were privileged to know this dedicated scientific worker for better human health. Well-trained, widely respected, and admired for his pediatric astuteness, Maynard died prematurely at 45, leaving a gap that will be impossible to fill and warm friendly memories which will endure as a living memorial to him. Typical of Maynard's approach to medical service was his practice of bawling out a parent who waited until morning to call him if the child became sick at 2 a.m. Dr.

Cohen was active in many community and medical services.

William Y. Marcus, M.D., was certified as a Diplomate of the American Board of Surgery.

William H. Killay, M.D., was certified as a Diplomate of the American Board of Internal Medicine.

Ira Wickner, M.D., wrote a scientific paper titled "Differential Diagnosis of Bronchial Asthma," which was published in our Medical Bulletin.

**Bernard H. Ostrow, M.D., Harold Passes, M.D., and Bert R. Boone, M.D.,** are physician-hosts for high school student seminars designed to stimulate interest in medical research. Almost 200 high school students

registered for the five seminar series; the students qualifying receive \$200 and at least two summer months fellowship in medical research at the National Institutes of Health or the National Naval Medical Center.

## WASHINGTON COUNTY MEDICAL SOCIETY

**JOHN D. TURCO, M.D.**  
*Journal Representative*

The regular dinner meeting of the Washington County Medical Society, Inc. was held at the Venice Restaurant on January 12, 1961.

The first part of the program concerned professional liability insurance. **Frank Lusby, M.D.,** chairman of the Statewide Committee on Insurance for the Medical and Chirurgical Faculty, explained the steps that have been taken in trying to find a reliable company to develop a policy for physicians at a reasonable rate. **Mr. John Barnes,** of the Saint Paul Fire and Marine Insurance Company, explained his company's policy, the benefits, and the rates, after which a film strip, "Sorry Doctor," was shown.

**Mr. Wilbur King,** director of the local Social Security office, introduced **Mr. Lee Burton,** chief, Disability Determination Unit, State Department of Education. Mr. Burton

discussed disability evaluation under Social Security and enumerated the different procedures that must be utilized in determining a patient's eligibility for disability. An excellent film, "Disability Decision," was shown.

The business meeting was presided over by the president, **Dalton M. Welty, M.D.** Dr. Welty announced that **W. T. Layman, M.D.,** has been appointed medical director of civilian defense in Washington County and urged all the members to cooperate with him as much as possible.

A special meeting was called on Thursday, January 26, to discuss the principle, "Should a physicians' fee relate directly to the service rendered, or should it relate to the extent of medical training of the physicians rendering the service?"

## WICOMICO COUNTY MEDICAL SOCIETY

**GLADYS M. ALLEN, M.D.**  
*Journal Representative*

The Wicomico County Medical Society held its first meeting of 1961 on January 9. Election of officers for the coming year was held. The new officers are: president, **Raymond M. Yow, M.D.;** vice president, **H. Gray Reeves, M.D.;** secretary-treasurer, **William S. Womack, M.D.**

After the election **Solomon H. Albert, M.D.,** director of research, Department of Anesthesiology, Washington Hospital Center, District of Columbia, and **Donald W. Benson, M.D.,** professor of anesthesiology, Johns Hopkins Hospital, spoke on the "Medical Applications Of Hypothermia."

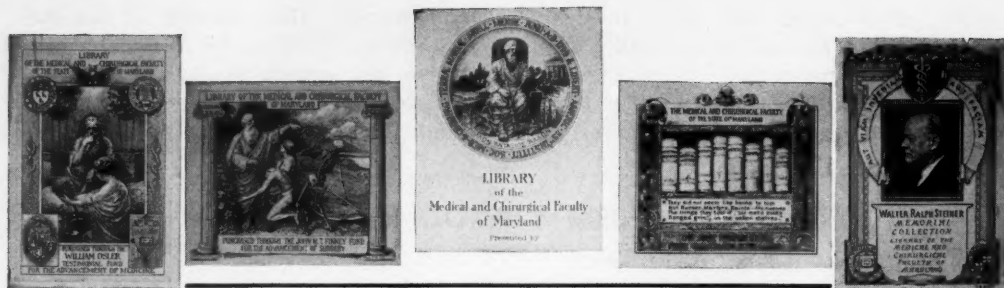
**The Gill Memorial Eye, Ear and Throat Hospital  
will hold its  
Thirty-Fourth Annual Spring Congress in  
Ophthalmology and Otolaryngology and Allied Specialties,  
April 10 through April 15, 1961.  
There will be 20 guest speakers and 50 lectures.**

### **WHAT'S ON YOUR MIND?**

In a proposed new feature to be headed THE OPEN FORUM, we invite you to share your views, to compliment or to criticize, to support or to refute ideas and issues of concern to Maryland physicians. Address your letters to The Open Forum, Maryland State Medical Journal, 1211 Cathedral Street, Baltimore 1, Maryland.

Please keep your letters brief and to the point. Your name and address must be included, but we will withhold your name upon request.

Errors in grammar, spelling, and punctuation will be corrected unless you specify that the letter be published as is.



## Library

Louise D. C. King, *Librarian*

"Books shall be thy companions; bookcases and shelves,  
thy pleasure-nooks and gardens." *Ibn Tibbon*

## Random Reading

**M**ARCH, WITH ITS fickle weather, is the forerunner of spring. It is a month of preparation and promise of a renewed life, and it is an excellent time to plan summer reading. There are so many fascinating books we have always wanted to read, but never have "gotten around to it." One way to circumvent the obstacles of inertia and a busy schedule is to form our own "Book of the Month Club" and pledge ourselves to read at least one book of our choice each month. This should not be too difficult even for the overworked physician and will be well worth the effort. We have listed for you a few small books in case you have no particular volume in mind. Your library will gladly send you any of these that may strike your fancy.

*Fulton, John F.*: Michael Servetus, Humanist and Martyr, New York, 1953

This small volume is packed with accurate facts of the martyr's contributions to physiology, his life and times. W. W. Francis, M.D., in a letter to Dr. Fulton, in speaking of Servetus' being burned at the stake says, "... They did it in the name of God to save souls, we do it in the name of Progress to save minutes."

*O'Malley, Charles D.*: Michael Servetus, Philadelphia, 1953

Composed principally of translations of some of the rarer writings of Servetus, with a short account of his life.

*Cunningham, H. H.*: Doctors in Gray, Baton Rouge, 1958

*Adams, George W.*: Doctors in Blue, New York, 1952

*Maxwell, William Q.*: Lincoln's Fifth Wheel, New York, 1956

These three small, readable volumes give an excellent picture of military medicine 100 years ago and should be of great interest to those who were engaged in either world war.

*Osler, Sir William.*: Men and Books, Pasadena, California, Priv. pr., 1959

"Men and Books snippets," as Sir William called them, are reprinted from the Canadian Medical Association Journal during 1912, 1913, and 1914. Anything by "The Chief" needs no comment.

*Simpson, R. R.*: Shakespeare and Medicine, Edinburgh, 1959

The medical lore displayed by The Bard may come as a surprise even to the physician who knows and loves his Shakespeare.

*Richardson, Robert G.*: The Surgeon's Tale, New York, 1958

This is a delightfully told history of surgery, much of it dealing with the twentieth century.

*Boas, Marie.*: Robert Boyle and 19th Century Chemistry, Cambridge, 1958

Because medicine owes so much to chemistry, and chemistry to Boyle, all physicians should derive profit and pleasure from reading this little book.

*Dubos, René.*: Louis Pasteur, Boston, 1950

Another chemist whose name is a household



word and to whom medicine is much indebted.  
*Young, Filson:* The trial of H. H. Crippen,  
London, 1950

Although somewhat lengthy, this trial of Dr. Crippen may interest those who like "whodunits."

*Shryock, Richard H.:* Medicine and Society in America 1660-1860, New York, 1960

Written interestingly and from the proper viewpoint of all special histories: with relation to the times.

*Gifford, Edward W.:* The Evil Eye, New York, 1958

In a few pages, Dr. Gifford contrives to deal with vision as a whole, in its psychological and emotional aspects as well as with the traditional superstitious angle. Absorbing reading.

*Kerényi:* Asklepios, tr. from the German by Ralph Manheim, New York, 1959

"In this book I invite the reader to accompany me on a tour of the sites where the cult of Asklepios . . . was practiced." Beautifully illustrated and particularly interesting to the lover of mythology.

*Goss, Charles M.:* Brief Account of Henry Gray, F.R.S., and his Anatomy, Philadelphia, 1959

For a book which has stood the test of 100 years usage by practically every English speaking student of medicine, surprisingly little is known of its author. Dr. Goss, the last editor, has given us a most interesting resume of Gray's life. He lists the various editions of this textbook.

*Singer, Charles:* Short History of Anatomy and Physiology from the Greeks to Harvey, New York, 1957

Dr. Singer, one of our ablest historians, has given us the highlights of many famous men in his usual erudite style.

*Davis, Audrey W.:* Dr. Kelly of Hopkins, Baltimore, 1959

Miss Davis, who worked with Dr. Kelly for twenty years, knew him as few others did. Her portrayal of this many faceted man is interesting and authoritative.

## MALPRACTICE INSURANCE POLICIES ARE NOT ALL THE SAME

Professional liability policies not only vary in the exclusions they contain and in the broadness of their insuring clauses, but may also differ through Company interpretation.

The Medical and Chirurgical Faculty of Maryland and the Baltimore City Medical Society have recently approved a policy of Professional Liability insurance which, through its broad insuring clause and absence of exclusions, assures you of professional service protection for the following types of claims many of which by interpretation are not covered under other forms:

1. Allegations of assault or battery usually arising out of lack of consent to surgery or going beyond consent given;
2. Allegations of libel and slander oftentimes arising from betrayal of professional confidence;
3. Allegations of personal restraint, false imprisonment and malicious prosecution most generally arising in the treatment of psychiatric patients;
4. Defense for allegations of undue familiarity and alleged illegal abortion. (The St. Paul policy provides for defense with no obligations for indemnification of the doctor if the court finds undue familiarity and/or an actual illegal abortion occurred);
5. Counterclaims (which arise when the doctor brings actions to collect fees);
6. Claims alleging libel and slander against a doctor who as a member of the medical staff of a hospital reports a colleague incompetent.

Check *your* policy's insuring agreement and exclusions—and then compare it with the approved policy written by the St. Paul Fire & Marine Insurance Company. THE VAN HORN-MUGNO COMPANY, an Independent Insurance Agency representing this fine Company in Maryland, will be glad to send you a copy of the St. Paul's comprehensive policy, and, if you desire, help fit this broader coverage into your present insurance program. Call The VAN HORN-MUGNO CO. at VALley 5-2004, or write:

The Van Horn-Mugno Co.  
23 E. Chesapeake Ave.  
Towson 4, Maryland

I am interested in obtaining more information on the Professional Liability Insurance Program endorsed by the Medical & Chirurgical Faculty of Maryland and the Baltimore City Medical Society.

Dr. ....  
Address .....  
Phone .....



*Maryland*  
**SOCIETY OF PATHOLOGISTS INC.**

EDWARD C. MCGARRY, M.D., *President*    MANNING W. ALDEN, M.D., *Secretary*  
Annapolis, Md.

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## MEDICAL ETHICS AND THE PRACTICE OF PATHOLOGY

**T**HE PRACTICE OF PATHOLOGY, because it is a relatively new specialty, presents problems of medical ethics which many other specialty practices have avoided. Prior to the past few decades, most hospitals operated clinical laboratories because pathologists were found only in the largest medical centers. These laboratories were generally supervised by a staff clinician as a supplementary duty. As pathologists became available, they were usually required to accept a salary to obtain a staff position. When Blue Cross was founded, laboratory services were included as hospital services.

In summary, do not think of tolerance in terms of maximum permissible dose, hospitals, a growing concern has arisen about medical ethics. Although the practice of pathology has been clearly defined by the AMA, the College of American Pathologists, and the Medical and Chirurgical Faculty of Maryland as the practice of medicine, hospitals continue to offer laboratory services as hospital rather than medical services. The AMA further states that it is unethical for a third party to collect the medical fee of any practicing physician. Therefore, the manner in which this specialty developed, together with its insurance coverage, has brought about a situation in which pathologists are unable, in general, to practice medicine in hospitals in a manner consistent with the ethics of the medical societies to which they belong.

The problem is further complicated by the recent publication by the American Hospital Association of a manual of principles dealing with hospital-physician relations which conflict in many respects with the ethics of organized medicine.

The implications of this situation may have detrimental consequences for all private practicing physicians and for the quality of laboratory medicine. A recent attempt has been made to offer pathology and radiology services on an out-patient basis in hospital out-patient departments under Blue Cross. If this attempt had been successful, it is reasonable to presume that other medical services would soon follow. If Blue Cross extends coverage to all medical services in the out-patient departments of hospitals, this might lead ultimately to a cessation of medical practice in the physician's private office.

Ethics are necessary in the practice of medicine so that physicians can offer the highest quality of medical service to patients in the most economical manner. In order to practice this quality of medicine, physicians, regardless of specialty, must remain independent of hospitals, insurance companies, and other lay organizations. If the private practice of medicine is to be preserved so that these high standards can be maintained, it is essential that all physicians be permitted to practice in an ethical manner and that the medical profession unite to prevent further encroachments on medical practice.

# MARYLAND RADIOLOGICAL SOCIETY

ORGANIZED 1953

Editor—William E. Peterson, M.D.

## CASE OF THE MONTH



PA chest film



A.P. 9cm. body section laminogram

65-year-old white male with a "chest cold" and progressive cough for three months. Whitish expectoration without hemoptysis. No weight change. Initial PA chest film shows round right cardiohepatic soft tissue mass, nodular hilus and fullness to the right of the tracheobronchial area. Body section film demonstrates better detail, notch on lesion toward the hilus (Rigler's Sign?) full nodular hilus, and clear space between the mass and the cardiac shadow. How would you diagnose this? Turn to page 163, for correct diagnosis.

## RADIATION PROTECTION IN CHILDREN

**R**ADIATION AS A HAZARD is not a new problem, but the advent of atomic energy has resulted in more awareness to the needs of protection from ionizing radiation. At the same time, medical radiation is recognized to be of enormous value, and its use should not be minimized. Throughout the years, there has been a lowering of the maximum permissible dose (MPD) for occupational workers to the present 5 REMS per year. For nonoccupational persons, the exposure levels are set at 1/10 of the MPD or 0.5 REMS per year. This is in addition to medical radiographs that may be required.

There are various ways that we may reduce the available exposure to a minimum:

1. Use good equipment, properly installed with regular monitoring.
2. Use relatively higher KV and heavier total filtration of at least 2½-3 mm. of aluminum.
3. Know the indications for types of various films, cassettes, and grids.
4. Do not use fluoroscopy when x-rays can give the same information. For example, a single chest film requires 0.025 r. If a conservative fluoroscopic output is 6 r/min. table top (10 r/min. is maximum accepted value), then radiation exposure during a single chest is equivalent to only ¼ second of fluoroscopy. A recent survey among pediatricians in a large midwestern city revealed that fluoroscopy was mainly employed and radiography used rarely. About 60 per cent of the units had useful beam dose rates greater than the accepted maximum allowed limits.
5. Limit the size of the beam either by shutter size in fluoroscopy or by use of cones or collimators in diagnosis.
6. Shield the gonads when feasible.
7. In children, adjust the fluoroscopy to lower output.
8. Avoid undiagnostic radiographs.

In summary, do not think of tolerance in terms of maximum permissible dose, but of minimal possible dose.

David D. Golub, M.D.



## MARYLAND TUBERCULOSIS ASSOCIATION

Christmas Seal Agency for State of Maryland

900 ST. PAUL STREET

BALTIMORE 2, MARYLAND

### SUSCEPTIBILITY AND IMMUNITY TO COMMON UPPER RESPIRATORY VIRAL INFECTIONS—THE COMMON COLD

*Studies with volunteers show that many viruses are found in the nasal secretions of people suffering from the common cold and that physiologic and psychologic factors influence the symptoms. Infection causes immunity, but immunologic control may be difficult.*

COMMON UPPER RESPIRATORY viral infections, despite their frequency, have been something of an enigma to physicians and scientists in general. Little has been known about their specific etiology and the factors that influence susceptibility or resistance to infection. A prevalent view, even within recent years, has been that there is a common cold virus to which only man is susceptible and which causes recurrent symptomatic infections without establishing immunity of the host. This concept now appears to be far too simple.

The present report gives results of experimental challenge of volunteer subjects with one of the common cold agents under controlled conditions.

Donors with naturally acquired typical common colds in the months from September to May have contributed specimens of nasal secretion. The secretions have been filtered free of bacteria and cells and stored at minus 90°F.

Students ranging in age from 18 to 48 have been challenged with a nasal secretion, usually diluted 100 times; a virus grown in tissue culture, or a salt solution. Symptoms were recorded for each day of the following week.

Nasal discharge was the symptom most uni-

formly recorded. It was the only symptom that was rated as severe. Sore throat, malaise, post-nasal discharge, headache, cough, and sputum were frequent symptoms of moderate severity. Feverishness and chilliness were reported infrequently.

#### BACTERIA CULTURED

Bacteriologic cultures of the nasal specimens before and on the fourth, seventh, and ninth days after challenge were made for the detection of pathogenic microorganisms in the respiratory secretions. Some of the volunteers harbored staphylococci, hemolytic streptococci, or pneumococci in their prechallenge specimens. There was no apparent relationship between the presence of these microorganisms and the development of clinical symptoms.

Among a control group of volunteers who received uninfected buffer solution, there was a direct and statistically significant relationship between the usual number of colds per year reported by the subject and the likelihood of his developing symptoms of a cold in the experiment. Thus, among 23 subjects who reported five or more colds per year and who received the noninfectious control inoculum, 26 per cent developed a cold according to the criteria used in the experiments. Among the subjects who reported fewer natural colds and received uninfected material, there was a proportionately smaller number of experimental colds.

Attitudes exhibited before challenge showed

George Gee Jackson, M.D.; Harry F. Dowling, M.D.; Truman O. Anderson, M.D.; Louise Riff, B.S.; Jack Saporta, M.S.; and Marvin Turck, M.D., *Annals of Internal Medicine*, October, 1960. Reprinted by the National Tuberculosis Association, *ABSTRACTS on Tuberculosis and Other Respiratory Diseases*, Feb., 1961. Vol. XXXIV, No. 2.



that cold symptoms would be less likely to be reported by individuals who (1) did not believe they would develop a cold, (2) thought that emotional status did not influence physical status, and (3) reported feeling no concern or worry over anything going on in their lives at the time of experimental challenge. A positive response to these three attitudes made it more likely that cold symptoms would be reported by the individual.

In regard to the effect of chilling on the common cold, the data show two important features: (1) among uninfected subjects, chilling did not activate latent viruses with the production of a clinical cold; (2) among subjects who received a uniform challenge, chilling did not increase the susceptibility to clinical infection.

Previous tonsillectomy had no influence on susceptibility or symptoms, nor did the smoking history of the person.

## DISCUSSION

The causative agents of the common cold appear to be several, perhaps many, different viruses. These viruses produce both clinical and subclinical infections in man. Each of the viruses can produce a variety of clinical syndromes, commonly classified under categories of common cold, undifferentiated upper respiratory infection, and "flu." The common cold viruses cause afebrile, acute coryza in the great majority of persons. With a few exceptions, these viruses have not been isolated, named, or well characterized.

The common cold viruses are present in infectious form in both the cells and the fluid of nasal secretions; the titer is sufficient to suggest that droplet spray could be an effective means of communicating infection. Person-to-person transfer, presumably by droplet spray, was observed to cause clinical illness in approximately 10 per cent of persons exposed under experimental conditions and in 17 to 55 per cent among family members. The viruses in the community at different times, however, appear to be immunologically different, and some seem to cause sharp waves of epidemic illness, whereas others are more endemic.

The strong positive correlation between the usual number of colds per year by history and symptomatic reaction to an innocuous instillation appears to establish a wide range of difference in the proneness of persons to develop rhinorrhea or coryza. The data do not permit a conclusion

as to whether physiologic or psychologic facts are dominant. On either basis, it is surprising that among the subjects who were hyperreactors to an uninfected solution, there was not greater susceptibility to clinical illness from a secretion containing an infectious agent.

For centuries men have associated the common cold with environmental chilling. The present data seem adequate to conclude that the basis of the association is not the direct activation of latent viruses by physical cold or physiologic reaction to chilling, since these factors did not produce colds without infection.

## IMMUNITY

Previous epidemiologic and experimental observations that show insignificant immunity to the common cold have failed to recognize the number of specific viruses involved. Neutralizing antibody has been demonstrated in the serum and nasal secretion, and immunity to a specific rechallenge is as complete as that observed for influenza under natural conditions of infection. The duration of immunity is not known, but it appears to remain through at least one respiratory disease season.

These observations require the postulate that each viral upper respiratory illness is a specific infection, and thus that the number of viruses responsible for these infections is very great. Under the concept that the common cold is caused by many specific agents, each of which elicits an adequate immune response, the likelihood of discovering a predominant common cold virus that maintains this role for a long time is quite unlikely. If this is the case, the logistics for immunologic control of the common cold may be very difficult.

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### *Case of the Month X-Ray Diagnosis:*

Inoperable poorly differentiated squamous cell bronchogenic carcinoma with extensive hilar and mediastinal metastases.

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## BALTIMORE CITY HEALTH DEPARTMENT

HUNTINGTON WILLIAMS, M.D.  
COMMISSIONER

P. O. Box 1877 Baltimore 3, Md.

Plaza 2-2000: Extension 307

*Learn To Do Your Part In The Prevention Of Disease*

### Highlights in Baltimore's Health in 1960

**P**RINCIPAL ADVANCE in the health of the city during 1960 was an eight per cent reduction in the infant mortality rate from that in 1959. Other positive aspects of Baltimore's health record for 1960 included: (1) the continuation of a low maternal mortality rate, (2) the completion of another year without a single case of diphtheria, and (3) a reduction in the number of children poisoned by eating lead paint.

Several unfavorable developments which occurred were: (1) an outbreak of paralytic poliomyelitis, (2) a further rise in reported cases of infectious syphilis over the low levels achieved several years ago, and (3) a disappointing slow-up in the decline of tuberculosis illness and mortality.

Important administrative plans and actions designed to promote the health of the city included: (1) the preparation of a plan to extend the Baltimore City Medical Care Program in order to provide medical benefits to residents 65 years of age and over who have low incomes but are not on the welfare rolls, (2) the establishment of an experimental neighborhood conservation program to evaluate the effectiveness of coordinated inspection and law enforcement activities in assuring improved housing, and (3) the undertaking of a survey, jointly by the United States Children's Bureau and the Baltimore City Health Department, to describe the health conditions in the major cities with a view toward improving the health services provided for mothers and children in underprivileged circumstances.

The death rate from all causes was 12.1 in 1960 compared with 12.0 in 1959, a difference of no importance. The principal causes of death maintained their relative positions. In order of frequency of occurrence, these were: diseases of the heart, cancer, cerebral hemorrhage, diseases of

early infancy, and accidents. In recent years, this sequence has not changed in any significant manner.

#### OTHER NOTABLE PUBLIC HEALTH EVENTS

1. On March 7, Mayor J. Harold Grady approved City Ordinance No. 223, a strong protective measure authorizing the City Health Department to regulate and control radiological health hazards in Baltimore. Passage of this ordinance in the City Council was supported by the Baltimore City Medical Society and the Baltimore Association of Commerce.

2. Preliminary findings from the Baltimore Study on the Effects of Housing on Health, first made public in June, revealed that improved housing actually causes improved health. This unique five-year study was conducted under the auspices of the Johns Hopkins School of Hygiene and Public Health, with support from the United States Public Health Service, the City Health Department, and the City Housing Authority.

3. The new Western Health District building, at 700 West Lombard Street, was put in active use early in the year. The new Druid Health District building, at 1515 West North Avenue, was nearing completion at the close of 1960.

4. Carefully controlled studies revealed that seven years of fluoridation of the city's water supply paid handsome dividends in the prevention of dental decay in children. Six-year-olds showed an average of 75 per cent fewer permanent teeth attacked by decay than did youngsters of the same age five years previously.

5. The Mayor's Neighborhood Conservation Committee was established, resulting in an improved civic battle against blight and slums

through well coordinated inspection and law enforcement efforts of the City's Building Inspection, Law, Health, Police, Fire, Public Works, Urban Renewal, and other official agencies.

6. The Health Department's programs for expanding the use of poliomyelitis vaccine, for advancing its work in mental hygiene, and for preventing lead paint poisoning in young children were pushed forward actively during the year.

*Huntington Williams, M.D.*

Commissioner of Health

## FOR SALE

Complete up-to-date office equipment for sale by gynecologist. Includes furnishings, books, and bound journals. Box #22, Maryland State Medical Journal, 1211 Cathedral Street, Baltimore 1, Maryland.

## CALENDAR OF EVENTS

### ► Saturday, March 18 ◄

#### MEDICINE 1961

4:30-5:00 P.M. WMAR-TV  
"Research in Diseases of Old Age,"  
Nathan Shock, Ph.D.

### ► Monday, March 20 ◄

#### SECTION ON INTERNAL MEDICINE, B.C.M.S.

8:15 P.M. 1211 Cathedral Street  
Hypertension. Herbert G. Langford, M.D., Associate Professor of Medicine, University of Mississippi School of Medicine, Jackson, Mississippi.

#### Discussants:

John Eager Howard, M.D., Professor of Medicine, The Johns Hopkins University School of Medicine.  
Samuel T. R. Revell, M.D., Professor of Medicine and Head of Division of Hypertension—Renal Disease, University of Maryland School of Medicine.  
Annual Business Meeting and Election of Officers will be held following the Scientific Program.

**PATHOLOGY SECTION, B.C.M.S.**  
8:00 P.M. Officers' Club Room,  
U. S. Public Health Service Hospital

► Tuesday, March 28 ◄  
**ANESTHESIA STUDY COMMITTEE**  
8:00 P.M. 1211 Cathedral Street

### ► Monday, April 10 ◄

#### SACRED HEART HOSPITAL MEDICAL STAFF

11:30 A.M.  
School of Nursing,  
Bellevue Street, Cumberland

### ► Tuesday, April 11 ◄

#### MARYLAND SOCIETY OF ALCOHOLISM

Officers and Executive Committee  
8:00 P.M. Council of Social Agencies,  
22 Light Street

### ► Wednesday, April 12 ◄

#### WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

12:00 Noon 1211 Cathedral Street  
Installation luncheon, election of officers and revision of Constitution and Bylaws. "Ladies in the Lobby," a skit directed by Mrs. James Willson.

**MARYLAND SOCIETY FOR  
MENTALLY RETARDED CHILDREN  
GREATER BALTIMORE CHAPTER**  
8:15 P.M. 2525 Kirk Avenue



## Woman's Auxiliary Medical and Chirurgical Faculty

MRS. E. RODERICK SHIPLEY *Auxiliary Editor*



MARCH, 1961

### Doctor's Day—March 30, 1961

**C**RITICISM is so much more prone than praise to meet the public eye. One day a year, March 30, we may rebut the criticisms by gently reminding everyone of the tremendous achievements our doctors have made possible.

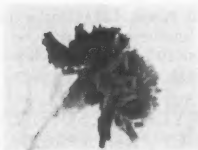
In tribute to Dr. Crawford Long's first using ether as an anesthetic on March 30, 1842, this day was officially designated Doctor's Day. It was first observed in Georgia approximately 25 years ago. Today almost every state pays tribute to its doctors on this occasion. Because of the use of the carnation in medical lore, the red carnation was adopted in 1949 as the official flower and symbol.

The doctor cannot and would not sound his own praise. Through the medium of Doctor's Day, we as doctors' wives hope to give the public a better appreciation of our husbands' personal sacrifices, their never-ending studies, and their humanitarian objectives.

Through the activities of the woman's auxiliaries in the counties, we hope our efforts to celebrate Doctor's Day will relay our sincere honor for the entire medical profession.

**Mrs. Irvin L. Wachsman  
Doctor's Day Chairman**

*From the Bulletin of the Woman's Auxiliary to the California Medical Society—*



**T**HE DOCTOR OF MEDICINE, by his devotion to his profession, by his training, and by his rather inflexible time schedule, is often limited in service he can offer to his community. It is here that the auxiliary, through community service, can make its contribution. The wife of a doctor of medicine, through her interest, her willingness to serve, her good judgment, and her





dissemination of correct information, can build a bridge of understanding between the doctor and the nonmedical community. Every task that the doctor's wife performs adequately, every service that she gives willingly to the life of her community brings honor to her auxiliary and to her husband's profession.

The medical profession is at the crossroads today. How medicine will be practiced in the future will soon be decided. It is necessary to emphasize to the public through every available means that working to improve today's medical system will provide better care in the long run than substituting a government system. It is vital that the profession enjoy a favorable climate of public opinion. The doctor's wife, remembering the theme of the year, "One's judgment can never be better than one's information," can by devotion and discretion help to establish a rapport between the medical profession and the community.

*From The Johns Hopkins Magazine, on the topic Medical Education—*

**T**HE SEARCH FOR UNITY in the field of medicine is complicated by problems that are reaching crisis proportions. The amazing progress of medical science in the past fifty years has yielded so much new knowledge that the traditional four-year medical curriculum is inadequate to encompass it.

Equally perplexing is the fact that time and expense involved in earning the M.D. and completing postdoctoral work are so great that many potential medical students are entering other sciences where they can earn their degrees in less time and where attractive student aid programs considerably ease the financial burden. As a result, the number of applicants to medical schools has

declined each year since 1957. This is an alarming trend and one which must be reversed if the nation's health is not to be endangered.

## News from Prince George's County

Prince George's Auxiliary held its annual benefit card party at the Prince George's Country Club, February 28, at 12:30 P.M. The proceeds from this party each year provide a nursing scholarship for a deserving candidate.

### Annual Meeting of The Woman's Auxiliary to the Medical and Chirurgical Faculty

April 27 and 28, Red Room,  
Sheraton Belvedere Hotel

#### Wednesday, April 27

- 9:00 A.M. Registration
- 10:00 A.M. General session
- 12:30 P.M. Luncheon (Charles Room),  
Mrs. William R. Mackersie,  
president of the Woman's  
Auxiliary to the AMA
- 2:00 P.M. Fashions by Dorothy Lovell

#### Thursday, April 28

- 9:00 A.M. Past presidents breakfast
- 10:00 A.M. Board meeting, Mrs. Norman  
Oliver, president

# Introducing

## Our County Presidents

*Mrs. George R. Spence, President  
Woman's Auxiliary to the  
Montgomery County Medical Society*



**M**RS. GEORGE R. SPENCE is a woman of many interests. She finds that running a home, helping occasionally in her pediatrician husband's office, and raising three sons isn't quite enough to keep her busy. So, in her spare time she is a den mother (this alone merits real applause) assists regularly in her children's school cafeteria, and is president of the Highland Fling Investment Club.

Edna Evensta was one of nine children of Norwegian descent. She was born in Brainard, Minnesota, and taught school in that state for six years.

She met and married George Spence while he was a resident at Childrens Hospital in Washington, D. C., and she was teaching in Arlington, Virginia. They now have three children: George, Jr., 18; Richard, 11; and Eugene, 9. Except during Dr. Spence's three years in the service, they have lived in the Washington area. In 1942, General Patton was as interested in acquiring good, young pediatricians as he was in acquiring infantrymen. On his return from army service, Dr. Spence became the second pediatrician to open a practice in Silver Spring, and he and his family have since watched a tremendous growth in medical facilities in the area.

The Highland Fling Investment Club, which Mrs. Spence organized and presides over, is a group of physicians' wives who, to quote from a recent article in the Bulletin of the Montgomery County Medical Society: "have concluded that it is neither safe nor sound to limit their knowledge and activities to being mothers and homemakers. Statistically, physicians' wives have every reason to believe that some day they will be forced to assume financial responsibility for their house, their investments and their worldly possessions. With this in mind, these women formed their own investment club in order to learn more about business procedure, terminology, and techniques. It is a different world from managing a grocery list, children's homework, and domestic problems. They are a serious minded group, yet have plenty of optimism about their future, as can be seen from their organizational name, 'The Highland Fling Club.'"

The group aroused so much interest among doctors' wives that Mrs. Spence organized a second investment group, with membership of each limited to 12 women.

Of the investment club the Montgomery County Medical Society Bulletin went on to say, "As physicians we salute them for three reasons:

First, they have done what we always tell our patients—'get a hobby.'

Second, it is a sound business program.

Third, they, being more economical than ourselves, may come through with the means of our spending our twilight years in luxury."